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1955

THE SENATE OF CANADA

PROCEEDINGS

OF THE

SPECIAL COMMITTEE ON THE

TRAFFIC IN NARCOTIC DRUGS IN CANADA

The Honourable TOM REID, *Chairman*

COMPLIMENTS OF
Tom Reid.

EDMOND CLOUTIER, C.M.G., O.A., D.S.P.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1955.



1955

THE SENATE OF CANADA

PROCEEDINGS

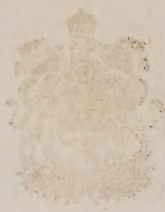
OF THE

SPECIAL COMMITTEE ON THE

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IN CANADA

The Honourable TOM REID, *Chairman*

•



1927

THE SENATE OF CANADA

SPECIAL COMMITTEE ON THE TRAFFIC IN NARCOTIC DRUGS IN
CANADA

The Honourable Tom Reid, *Chairman*.

The Honourable Senators:

Baird	Horner	Quinn
Beaubien	Howden	Reid
Burchill	Hugessen	Stambaugh
Gershaw	King	Turgeon
Grant	Kinley	Vaillancourt
Hayden	Leger	Veniot
Hawkins	McIntyre	Woodrow
Hodges	McKeen	

23 members — Quorum 7

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ORDER OF REFERENCE

Extracts from the Minutes of the Proceedings of the Senate.

THURSDAY, February 24, 1955.

The Honourable Senator Macdonald, P.C., moved, seconded by the Honourable Senator Godbout:—

1. That a Special Committee of the Senate be appointed to inquire into and report upon the traffic in narcotic drugs in Canada and problems related thereto.

2. That the said Committee be composed of the Honourable Senators Baird, Burchill, Gershaw, Grant, Hayden, Hawkins, Hodges, Horner, Hugessen, Leger, McDonald, McIntyre, Quinn, Reid, Stambaugh, Turgeon, Vaillancourt, Veniot and Woodrow.

3. That the Committee be empowered to send for persons, papers and records.

4. That the Committee be instructed to report to the House from time to time its findings, together with such recommendations as it may see fit to make.

The question being put on the said motion, it was—

Moved by the Honourable Senator Haig, seconded by the Honourable Senator Macdonald, P.C., that the name of the Honourable Senator Howden be added to the names of Senators appearing in the motion for setting up the Special Committee of the Senate to inquire into and report upon the traffic in narcotic drugs in Canada and problems related thereto.

The question being put on the amendment, it was—

Resolved in the affirmative.

The question being put on the main motion, as amended, it was—

Resolved in the affirmative.

WEDNESDAY, March 9, 1955.

With leave of the Senate, and—

On motion of the Honourable Senator Taylor for the Honourable Senator Macdonald, P.C., it was—

Ordered, That the name of the Honourable Senator Kinley be substituted for that of the Honourable Senator McDonald on the Special Committee on Traffic in Narcotic Drugs in Canada.

TUESDAY, March 22, 1955.

With leave of the Senate, and—

On motion of the Honourable Senator Beaubien, for the Honourable Senator Macdonald, P.C., it was—

Ordered, That the names of the Honourable Senators Beaubien, King and McKeen be added to the list of Senators serving on the Special Committee on Traffic in Narcotic Drugs in Canada.

L. C. Moyer,
Clerk of the Senate.

REPORTS TO THE SENATE

The Honourable Senator Reid, from the Special Committee appointed to inquire into and report upon the Traffic in Narcotic Drugs, presented the following Report:—

The said Report was then read by the Clerk, as follows:—

WEDNESDAY, March 2nd, 1955.

The Special Committee appointed to inquire into and report upon the Traffic in Narcotic Drugs beg leave to report, as follows:—

The Committee recommend:—

1. That its quorum be reduced to seven (7) members.
2. That it be authorized to print 800 copies in English and 200 copies in French of its proceedings, and that Rule 100 be suspended in relation to the said printing.

All which is respectfully submitted.

TOM REID,
Chairman.

With leave of the Senate,
The said Report was adopted.

WEDNESDAY, March 9th, 1955.

The Special Committee appointed to inquire into and report upon the Traffic in Narcotic Drugs in Canada beg leave to report, as follows:—

The Committee recommend that it be empowered to retain the services of counsel.

All which is respectfully submitted.

TOM REID,
Chairman.

With leave of the Senate,
The said Report was adopted.

TUESDAY, March 22nd, 1955.

The Special Committee appointed to inquire into and report upon the Traffic in Narcotic Drugs in Canada beg leave to report, as follows:—

The Committee recommend:—

1. That it be empowered to sit during sittings of the Senate, and also during adjournments of the Senate, and to adjourn from place to place as it may determine from time to time.
2. That it be authorized to employ such clerical and other assistance as it may deem necessary.

All which is respectfully submitted.

TOM REID,
Chairman.

With leave of the Senate,
The said Report was adopted.

WEDNESDAY, June 8, 1955.

The Special Committee on the Traffic in Narcotic Drugs in Canada begs leave to report, as follows:—

The Committee recommends that it be authorized to print 800 copies in English and 200 copies in French of its proceedings in blue book form, for distribution as the Committee may direct.

All which is respectfully submitted.

TOM REID,
Chairman.

With leave of the Senate,
The said Report was adopted.

FINAL REPORT AND RECOMMENDATIONS

THURSDAY, June 23, 1955.

The Special Committee of the Senate on the Traffic in Narcotic Drugs in Canada begs leave to present the following as its final report.

PART I—GENERAL

On February 24th, 1955, the following Resolution was adopted in the Senate:—

1. That a Special Committee of the Senate be appointed to inquire into and report upon the traffic in narcotic drugs in Canada and problems related thereto.
2. That the said Committee be composed of the Honourable Senators Baird, Burchill, Gershaw, Grant, Hayden, Hawkins, Hodges, Horner, Howden, Hugessen, Leger, McIntyre, Quinn, Reid, Stambaugh, Turgeon, Vaillancourt, Veniot and Woodrow.
3. That the Committee be empowered to send for persons, papers and records.
4. That the Committee be instructed to report to the House from time to time its findings, together with such recommendations as it may see fit to make.

On March 2nd, 1955, the following motion was passed, namely, that the Committee be authorized to print 800 copies in English and 200 in French, of the Proceedings, and that Rule No. 100 be suspended in relation to the said printing.

On March 2nd, 1955, it was resolved that the Honourable Senator Reid be elected Chairman of the Committee, and that a Steering Committee be appointed, the members of which shall be selected by the Chairman. It was further resolved that the quorum of the Committee be reduced to seven members.

The original membership of the Committee was changed on March 9th by the substitution of Honourable Senator Kinley for Honourable Senator McDonald, and on March 22nd by adding to the Committee Honourable Senators Beaubien, King and McKeen.

The composition of the Committee was then, and has remained, as follows:

The Honourable Tom Reid, *Chairman*.

The Honourable Senators:

Baird	Horner	Quinn
Beaubien	Howden	Reid
Burchill	Hugessen	Stambaugh
Gershaw	King	Turgeon
Grant	Kinley	Vaillancourt
Hayden	Leger	Veniot
Hawkins	McIntyre	Woodrow
Hodges	McKeen	

23 members — Quorum 7.

The members of the Steering Committee are Honourable Senators Burchill, Gershaw, Hayden, Horner and Reid.

On March 9, 1955, the Committee held a meeting, at which it was resolved to hear witnesses before the Easter adjournment, and it was further resolved that the Committee recommend that it be empowered to retain the services of counsel, and the services of Mr. A. H. Lieff, Q.C., of Ottawa, were retained.

In order to cover all foreseeable phases of the inquiry the Chairman held numerous conferences with individuals and with the Steering Committee, when it was resolved that the scope of the inquiry be as comprehensive as possible. To this end the Committee decided to hear evidence on all the ramifications of the drug problem including views of the addicts and of society in general. Because of the alarming proportions of the problem in British Columbia, and the amount of publicity given to that area of the problem it was resolved to hold sessions of the Committee in the City of Vancouver. It was felt that by so doing the Committee could bring before it all persons considered to be vitally interested and most closely concerned with the problem. Likewise an opportunity would be afforded to all others in British Columbia who wished to testify before the Committee.

For similar reasons it was decided to hold sessions of the Committee in the cities of Toronto and Montreal. By holding sessions in these three cities it was possible to have described, at first hand, the challenging character and extent of the problem and by so doing it was possible to conclude the sessions of the Committee during the present session of Parliament.

It was also resolved to interview a number of addicts and to visit one or more institutions in which addicts were confined.

The investigation by the Committee was directed to ascertaining the nature and extent of the narcotic drug problem in Canada and the gathering of such information as would enable the Committee to recommend possible solutions to the problem and necessary changes in the law.

On March 15th, 1955, the Committee held its first public hearing at the City of Ottawa, and further public hearings were held at Ottawa on March 22nd, 30th, May 11th, 17th, 20th, 25th, 27th, 30th and June 7th. Public hearings were held at Vancouver on April 18th, 19th and 20th, with hearings in camera on the 21st and 22nd. Public hearings were held at Toronto on May 20th and at Montreal on May 27th.

These were the first occasions on which any Committee of the Senate of Canada had ever held meetings in centres other than Ottawa.

Invitations to make representations to the Committee were extended to Attorneys General and Ministers of Health of all provinces and with the exception of the Province of British Columbia, all indicated they had no representations to make.

Similar invitations were sent to the Mayors of the cities of Montreal, Toronto, Winnipeg, Calgary, Edmonton, Vancouver and Victoria. Replies in the negative were received from Winnipeg, Calgary and Victoria.

The Committee held seventeen meetings all of which, with the exception of two were open to the public. The two closed meetings were devoted entirely to hearing the representations of narcotic drug addicts, at the R.C.M.P. Barracks in Vancouver, and at Oakalla Prison Farm in Burnaby, British Columbia. Twenty-one addicts and relatives or friends of addicts were heard at the R.C.M.P. Barracks, and at Oakalla Prison Farm Warden Christie convened a meeting of some 150 addicts in the chapel of the prison. During the latter meeting addicts made representations to the whole Committee.

Portions of several Committee meetings were closed to the public and were devoted exclusively to matters of procedure and the preparation of the Committee report.

A request was made to have the sessions held in Vancouver televised. It was deemed advisable, however, not to grant such request.

Evidence was adduced from government sources, including federal, provincial, and municipal authorities; from organizations and individuals; a list and classification of the witnesses is set out in Schedule 1 to this report (*See List of Witnesses*). Representations in the form of briefs, submissions and letters were received from a number of individuals and organizations. All of these representations were carefully considered and analyzed.

Valuable assistance was rendered to the Committee by the Mayors and municipal administrations of the cities of Vancouver, Toronto, and Montreal and by the Honourable R. W. Bonner, Q.C., Attorney-General of British Columbia. Special mention should be made of valuable assistance rendered by Mr. John A. Hinds, Assistant Chief Clerk of Committees and Mr. Robert E. Curran, Q.C., Counsel for the Department of National Health and Welfare.

Definition of Drug Addiction

For the purposes of the inquiry the Committee decided to adopt the definition of drug addiction approved by World Health Organization of the United Nations. It is as follows:

Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means.
2. A tendency to increase the dose;
3. A psychic (psychological) and sometimes a physical dependence on the effects of the drug.

Legislation

The Canadian legislation dealing with narcotic drugs is contained in the Opium and Narcotic Drug Act, R.S.C. 1952, C. 201 as amended by R.S.C. 1952, C. 325, S. 73, 1953-54, C. 38, and the regulations thereunder, (as made and established by Order in Council P.C. 1954-1212, effective September 15, 1954).

The purpose of the legislation is, firstly to make narcotic drugs available for medical and scientific purposes through trade and professional channels, and secondly the enforcement side.

By administrative arrangement the R.C.M.P. are responsible for the enforcement on the criminal side of the legislation, and the Department of National Health and Welfare, Division of Narcotic Control is concerned with the importation and legal distribution of drugs in Canada. The officers of the Department of National Health and Welfare work closely with the R.C.M.P.

The Committee desires to express its appreciation to the Honourable Paul Martin, Minister of National Health and Welfare for his assistance in outlining to the Committee the narcotic drug problem in Canada and for the co-operation given by him and by the officers of his department.

The Committee was favourably impressed with the efficiency of the administration of the Opium and Narcotic Drug Act by the Division of Narcotic Control of the Department of National Health and Welfare, headed by Mr. K. C. Hossick.

The Committee would also like to pay tribute to the Royal Canadian Mounted Police for the efficient manner in which they assist in the enforcement of the Opium and Narcotic Drug Act and for their co-operation and assistance to the Committee.

International Control

Canada has played an important role in international control and is a signatory to all international conventions designed to limit to medical and scientific uses narcotic substances. The Conventions Agreements and Protocols under which Canada participates in international control are listed in the evidence. Canadian legislation conforms in all respects with the requirements of the conventions and our international commitments, and from the evidence the Committee concurs with the statement of the Minister of National Health and Welfare that the Canadian legislation is as realistic and effective as the legislation of any country. Canada, as a member of the United Nations has, in keeping with other countries, members of the United Nations organization, agreed to make the legal importations of heroin illegal. The prohibition of heroin came into effect in Canada January 1st, 1955.

Traffic

The evidence indicates that, while Canada maintains excellent domestic control of licit narcotic drugs, international controls have not completely stopped the illicit flow of drugs into Canada.

The availability of drugs and the ease with which quantities of heroin can be secreted and transported makes it almost impossible to completely prevent smuggling of narcotic drugs into Canada across the long Canadian border. Some of the difficulties in denying entrance to illicit drugs have been explained to the Committee by officers of the R.C.M.P. and the evidence of Assistant Commissioner G. B. McClellan and Inspector J. J. Atherton is of special interest. It is the opinion of the Committee there exists in Canada an illicit drug traffic of which, at the present time, about one half is centred in British Columbia.

The illicit traffic seems to follow a complicated but well defined pattern. The traffic commences with the trafficker-importer who sells to a trafficker-wholesaler, who in turns sells to a trafficker-distributor. This is the hierarchy of the traffic and few if any of this class of distributor are addicts. The distributor then sells to:

1. The peddler or pusher who is not an addict.
2. The peddler or pusher who is an addict and who sells drugs to other addicts.

The Minister of National Health and Welfare and the Commissioner of the R.C.M.P. pointed out the extent of profit in the illicit drug trade. By way of illustration, an ounce of heroin has a legal value of approximately \$12.00. An ounce contains 437½ grains, an average dose being ¼ grain, or a total of 1,750 doses to the ounce. Almost invariably the drug will be heavily diluted or adulterated, thus multiplying 1,750 doses to a much greater number. With a dose or capsule selling for \$3.00 to \$5.00 in Vancouver, and as high as \$20.00 in Edmonton, the profits are truly enormous.

The profit motive needs no further comment. It is significant therefore that much of the evidence heard by the Committee urged the elimination of the profit motive in the sale of drugs.

Suggestions from witnesses for the accomplishment of this objective ranged from that of the legal supply of free drugs to the total segregation of all criminal addicts and the provision of the death penalty for important traffickers.

Extent of Addiction

Addicts in Canada have been classified as medical, professional and criminal. The latter has been defined in Canada as one who purchases his supply of drugs in the illicit market. It is this group that has given cause for the greatest concern.

Appendices A. to C. to the evidence of the Minister of National Health and Welfare respectively set forth a breakdown to the total addict population in Canada by classes; the criminal addict population by sex and age groups, and by occupation.

These figures indicate that at the present time there are in Canada 515 medical addicts, 333 professional addicts and 2,364 criminal addicts, totalling 3,212. Of the 2,364 criminal addicts, 1,101 are located in British Columbia.

Commissioner Nicholson, in discussing the results of a study made of 2,009 criminal addicts, stated that only 341 of this number were first convicted under the Opium and Narcotic Drug Act, 1,220 were first convicted first for some other offence, and the balance of 478 were addicts with criminal records other than narcotic drug convictions. As was explained by the Commissioner, of the 2,009 cases studied, 1,668 involved people who were very probably criminals before they were addicts.

The Committee is satisfied that there is no juvenile or teenage addiction problem in Canada. Of 2,364 known criminal addicts only twenty-six are under the age of twenty. These were not attending school when they became involved in the drug traffic and were already known to the police for juvenile delinquency.

Drugs of Addiction

The Minister of National Health and Welfare put on the record the drugs of addiction. "Narcotic drugs" are listed in the schedule to the Opium and Narcotic Drug Act. Reference to the schedule at the end of the Act will give the schedule of drugs which the department regards as problems. The drugs so listed come either from natural sources or synthetic.

The natural drugs come from opium, coca leaf or cannabis sativa commonly called hemp or marihuana. Opium produces morphine, heroin and codeine the principal drugs in use. Coca leaf produces cocaine and hemp produces cannabis sativa. Of all these drugs heroin is the one that is the most commonly employed for addiction in Canada.

Marihuana is not a drug commonly used for addiction in Canada, but it is used in the United States and also in the United Kingdom by addicts.

No problem exists in Canada at present in regard to this particular drug. A few isolated seizures have been made but these have been from visitors to this country or in one or two instances from Canadians who have developed the addiction while being in other countries.

The question of barbiturates was discussed. They are not narcotic drugs. They are covered insofar as use is concerned under the Food and Drugs Act.

The Committee is of the opinion that the present strict control of this drug should be continued and that a careful watch be kept of any unwarranted increase in their use, in order to prevent the abuse of such barbiturates.

Enforcement

The R.C.M.P. maintains drug squads at those centres where attention is indicated, reinforced as necessary by men from general duty and other specialist details. Most major Municipal Police Forces maintain special Narcotic Drug Squads which work closely with the R.C.M.P. The R.C.M.P. concentrates particularly on the investigation of traffickers.

The Committee finds that police co-operation is relatively good in most cities of Canada. Much of the co-operation depends on the personalities involved. Continued co-operation at all levels of enforcement by all police bodies with the R.C.M.P. appears to be essential, and where necessary, directives to this effect are urged.

The statement of Vancouver Chief of Police, Walter Mulligan that sixty per cent of the major crimes in Vancouver could be traced to narcotic drugs was contradicted by other responsible witnesses who testified that drug addicts seldom, if ever, engage in major or violent crime.

The statement made that shoplifting by addicts was responsible for most of the thefts from stores in Vancouver, amounting, it was stated, to millions of dollars annually, was not borne out by the evidence. The Hudson Bay Company, a large department store chain, which operated six stores in western Canada, advised the Committee that they have no way of knowing the exact amount of their losses due to actual shoplifting, but they did report that stock shortages in Vancouver due to clerical errors, internal theft, as well as shoplifting, are not any higher than the average pertaining in their six stores.

Treatment Proposals

Suggestions for treatment ranged all the way from the legal supply of drugs to the total segregation of all criminal addicts. The committee considered proposals to alleviate the drug problem that was submitted to it. These proposals included such matters as (a) the removal and segregation of all convicted addicts to an institution, far removed from any area of general population, preferably on an island, for long periods of time, coupled with some system of parole, where rehabilitation was indicated; (b) establishment of a treatment centre far removed from cities, with provision for compulsory confinement or isolation and control of an addict over a number of years; such an institution should emphasize mental care, complete rehabilitation and training for useful occupation; (c) provision for withdrawal treatment in general hospitals, establishment of a rehabilitation residence for men, foster home care for women; (d) narcotic clinics; (e) the British system; (f) community action; (g) education; (h) group therapy, such as is carried on by Alcoholics Anonymous and Narcotics Anonymous.

The Committee in making special reference to certain of these proposals also commends for careful study the evidence of those witnesses who spoke on the question of the treatment of drug addicts.

Narcotic Clinics

The Committee heard considerable evidence with respect to narcotic clinics and ambulatory treatment. The vast preponderance of responsible evidence on this subject, both oral and written, leads the Committee to conclude that the establishment of such clinics or the provision of any other legalized supply of drugs for the purpose merely of supporting addiction would be a retrograde step. The Committee is therefore strongly of the opinion that the narcotic drug problem cannot be solved by the creation of government clinics where addicts could obtain their supplies.

The Committee unanimously rejects any proposal designed to provide legal supplies of drugs to criminal addicts. The Committee was supported in this decision by evidence that the Narcotic Drug Commission of the United

Nations at its tenth session has resolved that "in the treatment of drug addiction methods of ambulatory treatment (including the so-called clinic method) are not advisable."

British System

The Committee heard frequent reference to the so-called "British System" and various witnesses urged its adoption in Canada. Consequently the Committee arranged to obtain firsthand information about the law pertaining to narcotic drugs in the United Kingdom. It was privileged to hear a comprehensive statement from Mr. J. H. Walker, United Kingdom Delegate to the United Nations Narcotic Commission. Mr. Walker explained the law relating to dangerous drugs in detail. He stated that dangerous (narcotic) drugs in the United Kingdom are subject to a wide degree of control of the exacting standards demanded by the International agreements to which the United Kingdom, in common with Canada, is a party. He also told the Committee that the indiscriminate administration of narcotic drugs to addicts is not now, and never has been, a feature of United Kingdom policy. A perusal of Mr. Walker's evidence would be most valuable to anyone interested in the British system.

The Committee was also privileged to hear evidence on this subject from Dr. A. W. MacLeod, Assistant Director, Montreal Hygiene Institute and Assistant Professor of Psychiatry, McGill University. Dr. MacLeod had experience in the treatment of drug addicts in Britain gained while he was assistant director of an in-patient psychiatric unit attached to one of the training hospitals at London University. He stated that the dangerous drug Inspectorate of the British Home Office was strongly opposed to any line of action that would allow a known addict to continue his addiction.

From the evidence it appears that there never has been a serious drug problem in the United Kingdom, and that the situation there is not comparable with that of Canada.

French System

The Committee regrets that Mr. Charles Vaille the Chairman of the United Nations Narcotic Commission and the French delegate to that Commission was unable to appear before the Committee. His co-operation in submitting a brief in explanation of the French System is greatly appreciated.

Education

The Committee considered the question of education against the use of narcotic drugs and is of the opinion that while educational programs may usefully be established for professional groups, for parent teacher associations, and for adult groups generally, such program should not be used where they would arouse undue curiosity on the part of impressionable persons or those of tender years. The Committee's view is supported by the Narcotic Committee of the United Nations who recommended against any such educational program. Lecture material especially prepared by the Division of Narcotic Control and containing information respecting the economic and social factors of drug addiction has been presented regularly to Medical and Pharmaceutical Associations, Schools of Nursing, and undergraduate societies in colleges of Medicine, Pharmacy and Nursing. This form of education should be continued.

The Committee recommends the improvement and expansion of mental health programs in our schools in the hope that variations from acceptable behaviour may be detected and treated before the opportunity for addiction to drugs has been presented.

Training Personnel

The Committee was gratified to hear evidence with respect to the high quality of narcotic drug research carried on by the Department of National Health and Welfare. Some of such research has attracted international attention. It may well be that Canada may become a narcotic drug research centre for students from other countries.

The Committee is of the opinion that the Government of Canada consider the possibility of making available bursaries or scholarships for the purpose of training medical, probation and rehabilitation personnel at institutions wherever such training is available.

Narcotics Anonymous and Alcoholics Anonymous

The Committee heard evidence that group therapy was of considerable advantage in the treatment of drug addicts. Two organizations which provide opportunities for group therapy are Alcoholics Anonymous and Narcotics Anonymous. Because there are many common factors in drug addiction as well as in alcoholism, both Alcoholics Anonymous and Narcotics Anonymous hold some promise for the rehabilitation of drug addicts. Both of these organizations aim to develop in the individual a desire to be cured.

Alcoholics Anonymous has been operating with commendable success for some time and beginnings have been made to establish chapters of Narcotics Anonymous. Of particular interest in this connection was the evidence of Dr. A. W. MacLeod of the John Howard Society of the Province of Quebec, and Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries.

One of the difficulties encountered in the establishment of Narcotics Anonymous was the difficulty in finding a sufficient number of addicts who were abstinent from the use of drugs for a sufficient length of time to provide a nucleus for successful group therapy. The Committee desires to encourage those engaged in this work and to express the hope that their efforts will meet with success.

Community Action

Any successful program for the prevention and treatment of drug addiction will require concerted community social action to remove from our cities those areas in which drugs are available, to provide adequate opportunity for youth and the emotional, social atmosphere which follows general rehabilitation efforts on behalf of treated drug addicts. There is an urgent need for communities to make concerted all-out efforts to eradicate conditions that breed drug addiction.

By the same token such groups as P.T.A., church groups, welfare councils, schools, hospitals, police, recreational bodies and employers and the public generally, will need to use their joint and several skills to readjust the lives of former addicts in order to again fit them into an ordered society. The importance of this is emphasized in the recommendations that are made in this report for a treatment program.

Research in British Columbia

The Committee took special notice of the research now being carried on at the University of British Columbia, under the direction of Dr. Geo. H. Stevenson. The Committee wishes to express its thanks to Dr. Stevenson for his efforts and for much important information given to the Committee on the subject of narcotic drug addiction.

PART 2

CONCLUSIONS AND RECOMMENDATIONS

Objectives

A solution of the narcotic drug problem involves the elimination of drug addiction, the suppression of the drug traffic and the prevention of an increase in the drug addict population.

Involved in these objectives is, of course, the protection of society at large against the evils of narcotic drugs.

Size of Problem

As previously stated the total known drug addict population in Canada is 3,212 of whom 2,364 are criminal addicts. Of the 2,364 approximately one-half are located in the City of Vancouver. The City of Montreal which is the largest city in Canada, has, a total criminal addict population of under 200 and the City of Toronto an addict population of under 400 with, according to the evidence, a large number of these being inactive or in other words as not having recently come to the attention of the enforcement authorities.

Pattern of Drug Addiction.

The Committee heard evidence from many expert and qualified witnesses concerning the kind of people who make up the criminal addict population of Canada, something of their background and, in addition, the Committee saw a large number of these people. Their sordid pattern of development shows a considerable degree of similarity.

There is frequently evidence of broken homes, poor environment, lack of parental control and discipline, and the absence of religious training. This background leads to social deviation, juvenile delinquency, crime and eventually to drug addiction through association with other drug addicts.

The evidence of medical authorities was to the effect that drug addiction is not a disease in itself. It is symptom or manifestation of character weaknesses or personality defects in the individual. The addict is usually an emotionally insecure and unstable person who derives support from narcotic drugs.

The Committee was gravely concerned to learn that relatively few cases could be authenticated where drug addicts, while out of custody, had been successful in abstaining from the use of drugs for any lengthy period of time.

The complications and difficulties in the successful treatment of drug addiction having regard to the pattern of development of the addict and his almost invariable criminal tendencies, cannot be too heavily stressed.

Jurisdictional Responsibilities

The Committee desires to emphasize that the solution of the problem of addiction, which of itself is of great complexity, is further complicated by the division of federal and provincial constitutional responsibilities.

In viewing the problem, it is necessary to distinguish the measures which the federal government can properly undertake by its legislation and the measures which constitutionally are of provincial concern.

The suppression of the illicit distribution and use of drugs is within the responsibility of the federal government. This, amongst other things, is the aim and purpose of the Opium and Narcotic Drug Act which provides for the legal distribution and use of drugs and the protection of society against the evils of the drug traffic and drug addiction.

The treatment of illness is a matter which comes within the responsibility of provincial authorities as, for example, mental illness and tuberculosis. Drug

addiction is considered by medical and social authorities to be a form of illness and the treatment of it as such is likewise within the jurisdictional responsibility of the provinces and of the communities therein.

A number of the provinces have recognized this responsibility in terms of special legislation for the treatment of drug addiction. The Provinces of Manitoba and Nova Scotia, as far back as the middle twenties, enacted special legislation entitled "The Narcotic Drug Addicts Act". The Province of Ontario has included in its Mental Hospitals Act and the Province of New Brunswick in its Provincial Hospital Act, provision for the committal and treatment of drug addicts. The Province of British Columbia, however, where the incidence of drug addiction is the highest, has no legislation in this regard and it was stated to the Committee that under the general hospital insurance plan in that province drug addiction was not a condition for which hospital treatment was authorized.

None of the provinces in Canada, however, have provided special institutional treatment facilities for drug addiction as such.

Situation in Vancouver, Montreal and Toronto

The addict population in the City of Vancouver was estimated to be from 1,100 to 1,500 and of this number slightly in excess of 300 are currently in jail or penitentiary. The remaining addicts at large in the city, according to the evidence, must purchase drugs once or more daily and in order to obtain the funds to do so engage in petty crime, such as shoplifting, thievery and, in the case of female addicts, in prostitution. These addicts have no gainful employment and support their addiction by vice and petty crime. They must, therefore, violate daily not only the Opium and Narcotic Drug Act in their illegal purchase and possession of drugs, but also the Criminal Code of Canada.

The Committee could not help but be disturbed by this large concentration of drug addicts and the apparent freedom with which they are able to congregate in the heart of the City of Vancouver. These people are known to engage in crime, including prostitution, and are without gainful employment of any kind. The Committee is not able to understand why the provisions of the Criminal Code dealing with vagrancy, prostitution and living off the avails of prostitution cannot be more effectively invoked to uproot and break up this concentration.

The Committee, in emphasizing this aspect of the situation, points out that the enforcement of the Criminal Code in the City of Vancouver is not a responsibility of the R.C.M.P., but is wholly a responsibility of the city police authorities.

The R.C.M.P. are concerned with the enforcement of the Opium and Narcotic Drug Act and in this connection concentrate essentially on the apprehension and conviction of drug traffickers.

The drug addict population, as already pointed out, are primarily criminal, engaged in crime daily apart from the violations of the Opium and Narcotic Drug Act. These people are, therefore, an enforcement responsibility of the city and the municipal authorities and a solution of the problem which they present requires much more than the enforcement of the Opium and Narcotic Drug Act. It requires vigorous police and community action if this evil social condition is to be successfully removed.

In contrast to the situation in the City of Vancouver, the Committee was impressed with the comparable drug situation in the Cities of Montreal and Toronto. In both of these cities the authorities now report a drug situation of relatively small proportions and one which is apparently under fairly good control.

The Committee is of the opinion that more vigorous effective enforcement of all pertinent law holds the answer to much of the problem in the City of Vancouver.

Treatment of Addiction a Provincial Responsibility

After a most careful and exhaustive examination of the evidence and of all the factors involved in treatment, the Committee is strongly of the opinion that the recognition of drug addiction as a treatment responsibility, with the provision of facilities therefor by provincial authorities, is long overdue.

The Committee in pointing out the responsibility of provincial authorities for treatment, does not minimize the difficulties that are presented nor the fact that a great number of drug addicts offer little or no promise for successful treatment. These difficulties would not in the opinion of the Committee justify the continued failure to provide treatment procedures and facilities.

The drug problem in Canada is essentially confined to the three provinces of Quebec, Ontario and British Columbia, of which the province of British Columbia has the largest concentration of drug addicts and, therefore, the greatest problem. As was pointed out there is no legislation nor are there facilities in that province for the treatment of drug addiction.

The Minister of National Health and Welfare in his statement to the Committee pointed out that he had gone on record with all of the provinces of Canada in drawing attention to the distinction between federal and provincial responsibilities in the matter of the drug problem. He pointed out that the federal government had offered to assist in any way that it could, within the limits of its authority and responsibility, in helping to find a solution to the problem of drug addiction.

As evidence of interest in the problem, Mr. Martin stated to the Committee that under date of December 3, 1954, he had offered to consider the availability to the Province of British Columbia of the federal Quarantine Station at William Head on Vancouver Island for use by the province as a treatment centre.

He also indicated to the provincial authorities in making such offer that the federal government would be prepared under the National Health Program to see whether or not financial assistance might be given to the renovation of such premises to make them more suitable for use as a treatment centre. No evidence was given to the Committee as to whether the offer was acceptable to the province.

The Committee makes specific reference to this proposal, because it is apparent that treatment of drug addiction, insofar as the treatment of a drug addict can be effective, depends upon the acceptance by provincial authorities, and particularly the Province of British Columbia, of responsibility for treatment with the provision of whatever facilities and legislative measures are required in that connection.

The evidence of many witnesses recommended the compulsory segregation and isolation of all addicts for long periods of time for the purpose of treatment and possible rehabilitation.

By using its constitutional powers, any province could pass the necessary legislation providing for the committal on a compulsory or voluntary basis, of drug addicts to an appropriate treatment institution in the same manner as is being done now for those in need of treatment for a mental condition.

In considering the various suggestions for treatment, it will be appreciated that the majority of addicts not only have known criminal records, but have, as well, character disorders, or personality disturbances which will require institutional treatment. Evidence about proposed treatment indicated that such treatment should include humane, supported withdrawal, medical treatment, post-discharge control, including long-term probation, coupled with the right of immediate return to the institution in the event of relapse.

It was also submitted that if treatment cannot be provided for all addicts, an effort should be made to treat at least the young ones, or those whose prognosis is good. It appears necessary to segregate young addicts from older addicts.

In commenting upon the responsibility of provincial authorities for the treatment of drug addiction, the Committee again stresses the need for community and public support of an addict who has undergone treatment and who desires to re-establish himself in society. It is apparent to the Committee that institutional treatment can do only so much for an addicted person.

The Committee draws attention to the evidence of a number of witnesses who strongly advocated the need for follow-up and supervisory facilities for addicts who had undergone treatment, to prevent a return to drugs or to former bad associates or habits.

To make treatment a practical possibility for those addicts who may offer some promise, the Committee would hope that provincial agencies, community agencies, voluntary agencies and the public generally, would do everything possible to assist in the acceptance into society of addicts who had been treated, including an opportunity of useful and gainful employment.

The Committee, therefore, strongly recommends the provision of suitable treatment facilities for drug addicts, and recommends for careful study by provincial authorities the evidence of those witnesses who discussed treatment, and particularly that of Dr. Harris Isbell who is possibly one of the world's foremost authorities on the subject.

Federal Responsibility

As has been pointed out, the responsibility of the federal government by its legislation is limited to the legal distribution of narcotic drugs for medical and scientific purposes and the suppression of the illicit use and distribution of those drugs. These measures are necessary for the protection of society.

The Committee points out that it is not within the constitutional authority of the federal government to assume responsibility for treatment of drug addicts nor to enact the kind of legislation necessary in that connection. This legislation would need to include the compulsory treatment of addiction, the legal supervision and control over the individual during treatment and the right of control of an individual following treatment to prevent his return to the use of drugs, former associations or habits. These are considered to be matters beyond the competence of the federal government.

According to the evidence of Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries, there are at the present time 369 criminal addicts in federal penitentiaries. These include both male and female criminal addicts.

It is pointed out that the kind of people who are sentenced to penitentiaries, for the most part, have a long and sordid record of crime behind them. These people are criminals from whom society is entitled to be protected. Their violations of the law coupled with their criminal backgrounds are such as to require their imprisonment for lengthy periods of time. It follows, therefore, that any possibility for treatment of addicts who are sentenced to penitentiaries will offer considerably less hope than would be the case of the early offender or the addict beginner. The best hope of successful treatment of a number of people who eventually come to the attention of the penitentiary authorities would seem to lie in early rehabilitative and corrective measures.

The Committee appreciates the difficult problem presented by the kind of criminal addicts who are sentenced to penitentiaries. The Committee, however, suggests that the penitentiary authorities might give further consideration to the particular problems presented by criminal addicts in terms of possible

segregation, treatment including specialized training and rehabilitation and other measures necessary in view of the special problems which addiction superimposes.

Penalties for Trafficking

As already pointed out the responsibility of the federal government is essentially concerned with the enforcement of the Opium and Narcotic Drug Act to eliminate the drug traffic and to prevent the spread of the contagion of addiction. It is felt by the Committee that vigorous enforcement, more severe penalties and a realistic recognition by judicial and other authorities of the extent and nature of the evil will do much to reduce the incidence of drug addiction in Canada.

The Committee notes with interest the evidence of Commissioner Harry J. Anslinger, Commissioner of Narcotics in the United States, before a Special Committee of the United States Senate wherein he pointed out that in areas where low sentences were imposed, the drug problem substantially increased and in areas where there was strict enforcement with heavy sentences the drug problem showed a commensurate decrease.

The Opium and Narcotic Drug Act provides penalties of up to fourteen years imprisonment for trafficking and for possession of drugs for the purpose of trafficking. The Act, properly, does not draw a legal distinction between the addict-trafficker and the non-addict-trafficker. The elimination of trafficking in drugs is the goal of enforcement and the attainment of this goal is not assisted by artificial distinctions between motives for trafficking.

The Committee heard considerable evidence regarding the heavy profits of the drug trafficker and various suggestions were advanced as to how this profit could be taken out of the traffic.

It is the considered opinion of the Committee that the most effective way of taking the profit out of the drug traffic is by making all trafficking, in terms of penalties, a most hazardous and costly undertaking to the trafficker.

The non-addict-trafficker, who is sometimes referred to as the "higher up" must depend upon a large number of agents or distributors to peddle the drugs which he imports but with which he seldom comes into contact. The imposition of heavy compulsory minimum sentences for trafficking is suggested as a deterrent to these hiring peddlers or pushers of the "higher up". If the higher up is not able to find a ready supply of assistants to distribute drugs to the addict population the availability of drugs to addicts may be reduced to a possible minimum.

The Committee considers that the penalties for trafficking regardless of purpose, motive or amount irrespective of whether the trafficker is or is not an addict, should be made more severe, with a compulsory lengthy minimum sentence and an increased minimum for a second or subsequent offence and possibly a maximum of life imprisonment.

In advocating the increase of penalties the Committee intends that this should serve as a clear warning to all who are addicted that if they engage in the distribution of drugs in any quantity for any purpose and regardless of their motives, they can expect to be dealt with as traffickers and given heavy penalties. It is the considered view of the Committee that this will act as an effective deterrent to a large number of drug addicts who might be tempted to assist in distribution and with their elimination as distributors the problem of the "higher up" in getting rid of his drugs is made more difficult.

The Committee in urging severe penalties for all traffickers does not of course minimize the necessity to continue intensive enforcement in an effort to eradicate the "higher up" from this evil market.

The Committee recognizes that illicit drugs are in the first instance imported into Canada by trafficker-importers. These trafficker-importers, however, seldom if ever physically carry into Canada the drugs for which they are responsible. This transportation is almost invariably done by agents or hirelings for a financial reward or perhaps for a share in the drugs. The Committee strongly recommends the establishment of a special offence with a penalty of the utmost severity for the illicit importation of drugs into Canada. The Committee in making this suggestion feels that a severe penalty may act as an effective deterrent to an individual in smuggling drugs into Canada for the profit of a "higher up".

Evidence was given to the Committee of the skill and efficiency by which traffickers and distributors endeavour to avoid detection and conviction.

The trafficker importer as mentioned, seldom has physical possession of the drugs for which he is responsible and he is rarely addicted to their use.

The trafficker distributors again are seldom addicted and they too, endeavour to avoid physical contact with the drugs that they distribute. The difficulty, therefore, of apprehending the trafficker importer or the trafficker distributor in possession of drugs is apparent. The efforts of the enforcement authorities as pointed out by the Commissioner, R.C.M. Police, in apprehending and convicting since 1949, 36 major traffickers who received penalties ranging from two to twenty-eight years' imprisonment is, in the opinion of the Committee, worthy of commendation.

The apprehension and conviction of the street peddler is one of difficulty. Enforcement has taught the peddler to be wary of strangers. He uses every device to plant drugs in convenient caches and thus in completing a transaction, avoids the risk of selling to an undercover agent. The Committee therefore suggests that special attention be given by the authorities to the possibility of the facilitation of proof of trafficking at all levels, having regard to the skill and cunning displayed by traffickers and distributors, illustrations of which were given by the enforcement authorities.

It is considered by the Committee that the evil of trafficking to be eliminated requires the most effective sanctions that can be devised and the provision of such facilities in the matter of proof of trafficking as are necessary to combat the traffic.

The Committee heard evidence from one of Canada's most experienced prosecutors under the Opium and Narcotic Drug Act, with respect to the difficulty in getting proper evidence to lay before the Court in cases of traffic conspiracy. He cited Sections 15 and 18 of the Opium and Narcotic Drug Act which facilitate proof in charges under that Act but stated that these were not available to the Crown in prosecutions of conspiracy to commit an indictable offence under the Opium and Narcotic Drug Act. The Committee recommends a study of the Act with a view to amending legislation to overcome the difficulty.

At this point it might be stated that in order to strengthen the hands of enforcement agencies, in addition to changes in the Opium and Narcotic Drug Act, amendments are indicated, to the Juvenile Delinquents Act and the Criminal Code of Canada.

The Committee recommends consideration of amendments to Section 33 (1) of the Juvenile Delinquents Act which would make association of an addict with a juvenile, *prima facie* evidence of contributing to delinquency. It must be borne in mind that the drug addict carries a communicable condition and merely by associating with a non-addicted juvenile is conducting himself in a manner likely to make such child a juvenile delinquent.

Since trafficking has become a mobile industry courts should withdraw driving privileges for long periods of time from all those convicted of offences

under Section 4 (3) of the Opium and Narcotic Drug Act. To give them authority so to do would require an amendment to Section 225 (1) of the Canadian Criminal Code adding the offences set forth in Section 4 (3) of the Opium and Narcotic Drug Act.

In advocating more severe and increased penalties for trafficking with a compulsory minimum, the Committee does not do so in criticism of the length of sentences that have ordinarily been meted out to traffickers. The Committee does so having regard to the elimination of street distributors, the discouragement of addicts to engage in the trafficking or transporting of drugs. There will thus be a clear and unequivocal warning to all addicts of the consequences which they can expect if they choose for any reason to become involved in the distribution of drugs.

Heavy penalties and intensified enforcement against street drug peddlers are therefore strongly urged, and in this way the Committee believes that the heavy profit motive will most effectively be taken out of the drug trafficking.

The Committee desires to express its appreciation to all witnesses who appeared before the Committee or supplied briefs. Particular mention should be made of Chief Constable W. H. Mulligan, Vancouver, B.C., Chief Constable M. F. E. Anthony, Edmonton, Alta., Mr. John W. Walker, United Kingdom Delegate to the United Nations Narcotic Commission, and Dr. Harris Isbell, Director of Research, United States Public Health Hospital, Lexington, Kentucky, all of whom travelled to Ottawa to appear before the Committee in person.

A copy of the Committee's Minutes of Proceedings and Evidence is tabled herewith.

All which is respectfully submitted.

TOM REID,
Chairman.

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MINUTES OF PROCEEDINGS

WEDNESDAY, March 2, 1955.

Pursuant to Rule and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 11.30 a.m.

Present: The Honourable Senators: Baird, Burchill, Gershaw, Hayden, Hodges, Horner, Howden, Hugessen, Leger, McIntyre, Quinn, Reid, Turgeon, Vaillancourt and Veniot—15.

On motion of the Honourable Senator Howden, the Honourable Senator Reid was elected Chairman.

Following discussion it was Resolved that a Steering Committee be appointed, the membership to be selected by the Chairman.

(The Honourable Senators Burchill, Gershaw, Hayden, Horner and Reid were selected to comprise the Steering Committee.)

It was Resolved to report as follows:—

The Committee recommend:

1. That its quorum be reduced to seven (7) members.
2. That it be authorized to print 800 copies in English and 200 copies in French of its proceedings, and that Rule 100 be suspended in relation to the said printing.

At 11.45 a.m. the Committee adjourned to the call of the Chairman.

TUESDAY, March 15, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators: Reid, Chairman; Baird, Gershaw, Grant, Hodges, Horner, Howden, Leger, Quinn, Stambaugh, Turgeon and Veniot—12.

In attendance: The official Reporters of the Senate.

The Honourable Paul Martin, Minister of National Health and Welfare, read a prepared statement and was questioned by members of the Committee.

The following documents were tabled:—

Opium and Narcotic Laws of the United States.

The Dangerous Drugs Act for the United Kingdom.

The Mental Hygiene Act, Saskatchewan.

The Narcotic Drug Addicts Act, Manitoba.

The Mental Hospitals Act, Ontario.

The Private Sanatoria Act, Ontario.

The Psychiatric Hospitals Act, Ontario.

The Provincial Hospital Act, New Brunswick.

The Narcotic Drug Addicts Act, Nova Scotia.

The Mental Diseases Act, Alberta.

The following documents, filed by the Minister, were ordered to be printed as Appendices to these proceedings:

Appendix A. Total Addict Population by Classes.

Appendix B. Total Criminal Addict Population by Sexes and Age Groups.

Appendix C. Total Criminal Addict Population by Occupation.

On motion of the Honourable Senator Turgeon, it was resolved that the services of Mr. A. H. Lieff, Q.C., of Ottawa, Ontario, be retained as counsel to the Committee.

At 12.30 p.m. the Committee adjourned until Tuesday, March 22, at 10.30 a.m.

TUESDAY, March 22, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators—Reid, Chairman; Baird, Burchill, Gershaw, Hayden, Hawkins, Hodges, Howden, Leger, Quinn, Stambaugh, Turgeon, Vaillancourt and Veniot—14.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

Commissioner L. H. Nicholson, R.C.M.P., read a prepared statement and was questioned by counsel and members of the Committee.

The following documents, filed by the Commissioner, were ordered to be printed as appendices to these proceedings:

Appendix D. R.C.M.P. Narcotic Convictions Annually since 1921.

Appendix E. Location and Records of Criminal Addicts.

On Motion of the Honourable Senator Burchill, seconded by the Honourable Senator Hodges, it was resolved to report as follows:—

The Committee recommend:—

1. That it be empowered to sit during sittings of the Senate, and also during adjournments of the Senate, and to adjourn from place to place as it may determine from time to time.

2. That it be authorized to employ such clerical and other assistance as it may deem necessary.

At 11.50 a.m. the Committee adjourned.

At 2.30 p.m. the Committee resumed.

Present: The Honourable Senators—Reid, Chairman; Baird, Gershaw, Hayden, Hawkins, Hodges, Howden, Leger, Quinn, Stambaugh, Turgeon and Vaillancourt—12.

Mr. K. C. Hossick, Chief, Narcotic Control Division, Department of National Health and Welfare, read a prepared statement and was questioned by counsel and members of the Committee.

"Drug Addict", a film by the National Film Board, was shown under the direction of Mr. Hossick.

Dr. C. A. Roberts, Chief, Mental Health Division, Department of National Health and Welfare, read a statement and was questioned by counsel and members of the Committee.

At 4.35 p.m. the Committee adjourned until Wednesday, March 30, at 10.30 a.m.

WEDNESDAY, March 30, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators: Reid, Chairman; Baird, Beaubien, Gershaw, Hayden, Hawkins, Hodges, Howden, Hugessen, Leger, Quinn, Stambaugh, Turgeon and Vaillancourt.—14.

In attendance:

Mr. A. H. Leiff, Q.C., Committee Counsel.

Chief Constable W. H. Mulligan, Vancouver, B.C., read a prepared statement and was questioned by Counsel and members of the Committee.

The following documents were tabled:—

List of Persons Charged under the Opium and Narcotic Drug Act.

List of Drug Suspects.

Vancouver Police Department Criminal Records.

A table of drug arrests and convictions, 1951-54, was ordered to be printed as Appendix F to these proceedings.

At 12.15 p.m. the Committee adjourned until 10.00 a.m. Monday, April 18th next, at Vancouver, B.C.

Court House, Vancouver, B.C.,
MONDAY, April 18, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.00 a.m.

Present: The Honourable Senators Reid, Chairman; Beaubien, Gershaw, Hodges, Horner, Howden, King, Leger, McKeen, Stambaugh and Turgeon—11.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

His Worship Mayor F. A. Hume, Vancouver, B.C., was heard.

Dr. G. H. Stevenson, Director, Drug Addiction Research, University of British Columbia, was heard and questioned by counsel and members of the Committee.

At 12.10 p.m. the Committee adjourned.

At 2.00 p.m. the Committee resumed.

Dr. G. H. Stevenson was further heard and questioned.

The following documents, filed by Dr. Stevenson, were ordered to be printed as Appendices to these proceedings:

Appendix G: Arguments for and against the Legal Sale of Narcotics.
Appendix H: You can Prevent Drug Addiction and Cure Victims of Habit.

The following were heard and questioned by Counsel and members of the Committee:

Dr. J. Ross MacLean, Vancouver, B.C., physician.

Senior Major John Steele, Public Relations Dept., The Salvation Army, Vancouver, B.C.

Captain William Leslie, Officer in Charge, Harbour Light Center, The Salvation Army, Vancouver, B.C.

His Worship Magistrate Oscar Orr, Vancouver Magistrate's Court.

At 4.45 p.m. the Committee adjourned until tomorrow, Tuesday, April 19, at 10.00 a.m.

Court House, Vancouver, B.C.,
TUESDAY, April 19, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.00 a.m.

Present: The Honourable Senators: Reid, Chairman, Beaubien, Gershaw, Hodges, Horner, Howden, King, Leger, McKeen, Stambaugh and Turgeon.—11.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The following read prepared statements and were questioned by Counsel and members of the Committee:

Dr. R. G. E. Richmond, Physician, Oakalla Prison Farm, Burnaby, B.C.

("Withdrawal Routine", a document filed by Dr. Richmond, was ordered to be printed as Appendix I to these proceedings.)

Mr. Hugh Christie, Warden, Oakalla Prison Farm, Burnaby, B.C.; Mr. E. E. Winch, M.L.A., Vancouver, B.C.; Mrs. Edna MacCullie, Vancouver, B.C.;

At 12.45 p.m. the Committee adjourned.

At 2.00 p.m. the Committee resumed.

Present: The Honourable Senators Reid, Chairman, Beaubien, Gershaw, Hodges, Horner, Howden, King, Leger, McKeen, Stambaugh and Turgeon.—11.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The following read prepared statements and were questioned by Counsel and members of the Committee:

Dr. James G. Foulks, Chairman, Committee on Prevention of Narcotic Addiction, the Community Chest and Council of Greater Vancouver.

Dr. Lawrence E. Ranta, Chairman, Health Division, The Community Chest and Council of Greater Vancouver.

Rev. Dr. J. Dinnage Hobden, Executive Director, John Howard Society of B.C.

At 4.15 p.m. the Committee adjourned until tomorrow, Wednesday, April 20, at 10.00 a.m.

Court House, Vancouver, B.C.,
WEDNESDAY, April 20, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.00 a.m.

Present: The Honourable Senators Reid, Chairman; Beaubien, Gershaw, Hodges, Horner, Howden, King, Leger, McKeen, Stambaugh and Turgeon—11.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The following read briefs and were questioned by Counsel and members of the Committee:—

Dr. A. W. Bagnall, British Columbia Medical Association.

Superintendent J. C. Horton, Vancouver Police Department.

Detective Rex Cray, Vancouver Police Department.

At 11.45 a.m. the Committee adjourned.

At 2.00 p.m. the Committee resumed.

Present: The Honourable Senators Reid, Chairman; Beaubien, Gershaw, Hodges, Horner, Howden, King, Leger, McKeen, Stambaugh and Turgeon—11.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The following read briefs and were questioned by Counsel and members of the Committee:—

Dr. George Elliott, Assistant Deputy Minister, British Columbia Department of Health.

Mr. R. S. Douglass, Warden, New Westminster Penitentiary.

(Statistics of Drug Addicts in B.C. Penitentiary, filed by Warden Douglass, were ordered to be printed as Appendix J to these proceedings.)

Dr. Allan Davidson, Assistant Director, British Columbia Mental Health Services.

His Worship Magistrate T. Dohm, Vancouver, B. C., was heard and introduced a male addict who was questioned by the Magistrate and members of the Committee.

Sgt. Harold Price, R.C.M.P., read a brief and was questioned by Counsel and members of the Committee.

At 4.15 p.m. the Committee adjourned until tomorrow, Thursday, April 21, at 10.00 a.m.

R.C.M.P. Barracks,
Vancouver, B. C.,
THURSDAY, April 21, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.00 a.m.

Present: The Honourable Senators Reid, Chairman; Beaubien, Gershaw, Hodges, Horner, Howden, Leger, McKeen, Stambaugh and Turgeon.—10.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

A number of addicts and relatives of addicts, appearing at their own request, were heard and questioned by Counsel and members of the Committee.

Following discussion, it was Resolved as follows:—

1. That with a view to safeguarding the anonymity of the witnesses, the transcript of evidence be not printed.
2. That Committee Counsel be directed to prepare a summary of the evidence heard, the said summary to be printed as Appendix K to these proceedings.

Reverend William Blackburne, Vancouver, B.C., was heard.

Committee Counsel submitted reports of the Vancouver City Police Department for the years 1948, 1950, 1951, 1952, 1953, and drew attention to a comparative table of miscellaneous crime for the period 1944-1953.

Ordered that the said table be printed as Appendix L to these proceedings.

At 5.15 p.m. the Committee adjourned until tomorrow, Friday, April 22, at 10.00 a.m.

OAKALLA PRISON FARM.
BURNABY, B.C.

FRIDAY, APRIL 22, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs met this day at 10.00 a.m.

Present: The Honourable Senators Reid, Chairman, Beaubien, Hodges, Horner, Howden, Leger, Stambaugh and Turgeon.—8.

In attendance: Mr. A. H. Lief, Q.C., Committee Counsel.

Under the direction of Mr. Hugh Christie, Warden of Oakalla Prison Farm, one hundred and fifty addict prisoners were assembled before the Committee. Twelve prisoners were heard and questioned by members of the Committee.

A summary by Committee Counsel of the evidence heard was ordered to be printed as Appendix M to these proceedings.

At 12.15 p.m. the Committee adjourned until Wednesday, May 11, 1955.

WEDNESDAY, May 11, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 8.00 p.m.

Present: The Honourable Senators Reid, Chairman, Baird, Gershaw, Hayden, Hawkins, Hodges, Howden, King, Kinley, Leger, Quinn, Stambaugh, Turgeon, Vaillancourt and Woodrow.—15.

In attendance: Mr. A. H. Lief, Q.C., Committee Counsel.

Chief Constable M. F. E. Anthony, Edmonton, Alberta, read a prepared statement and was questioned by Counsel and members of the Committee.

The following documents, submitted by Mr. R. S. S. Wilson (formerly Superintendent, R.C.M.P.), were ordered to be printed as Appendices to these proceedings:—

Appendix N. Cure and Control of the Addict as the Final Solution to the Narcotic Problem.

Appendix O. Drug Clinic Plan Opposed in Canada.

At 9.10 p.m. the Committee adjourned until Tuesday next, May 17, at 10.30 a.m.

TUESDAY, May 17, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators: Reid, Chairman; Baird, Gershaw, Hawkins, Hodges, Horner, Howden, Leger, McIntyre, Stambaugh, Turgeon, Veniot and Woodrow—13.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

Mr. John H. Walker, United Kingdom Delegate to the United Nations Narcotics Commission, read a prepared statement and was questioned by Counsel and members of the Committee.

A brief submitted by Mr. Charles Vaille, representative of France on the United Nations Narcotics Commission, was ordered to be printed as Appendix P to these proceedings.

At 11.40 a.m. the Committee adjourned until Friday, May 20, at Toronto, Ontario.

City Hall, Toronto, Ont.

FRIDAY, May 20, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 9.30 a.m.

Present: The Honourable Senators: Reid, Chairman; Gershaw, Hayden, Hodges, Horner, Howden, Leger, Stambaugh, Turgeon and Woodrow—10.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The following read prepared statements and were questioned by Counsel and members of the Committee:

Assistant Commissioner G. B. McClellan, Officer Commanding "O" Division, R.C.M.P.

(A table filed by the witness, "Number of Prosecutions entered Yearly During Period January 1, 1940 to December 31, 1954" was ordered to be printed as Appendix Q to these proceedings.)

Chief Constable John Chisholm, Toronto, Ontario.

(A table filed by the witness, "Number of Persons Charged with Breaches of the Opium and Narcotic Drug Act 1946 to April 20, 1955 inclusive was ordered to be printed as Appendix R to these proceedings.)

Dr. R. C. Montgomery, Director of Mental Health Division, Ontario Department of Health.

(Tables showing first admissions and patients in residence in Ontario Hospitals suffering from drug addiction, filed by Dr. Montgomery, were ordered to be printed as Appendix S to these proceedings.)

Dr. F. H. Van Nostrand, Director of Neurology and Psychiatry, Ontario Department of Reform Institutions.

Dr. J. R. Mutchmor, Secretary, Board of Evangelism and Social Service of the United Church of Canada.

Mr. R. S. Beames, Casework Supervisor, John Howard Society of Ontario.

Dr. J. G. Hall, Welfare Council of Toronto.

At 12.15 p.m. the Committee Adjourned.

At 2.25 p.m. the Committee resumed.

Present: The Honourable Senators: Reid, Chairman; Gershaw, Hodges, Horner, Howden, Leger, Stambaugh, Turgeon and Woodrow—9.

Mr. N. L. Mathews, Q.C., Toronto, Ont., was heard and questioned by Counsel and members of the Committee.

Colonel Ervin Waterston, Secretary for Men's Social Service, The Salvation Army, read a prepared statement and was questioned by Counsel and members of the Committee.

A male and a female addict (designated Mrs. X and Mr. Y), appeared at their own request and were heard and questioned by Counsel and members of the Committee.

At 4.20 p.m. the Committee adjourned until Wednesday next, May 25, at 10.30 a.m.

WEDNESDAY, May 25, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators Reid, Chairman, Baird, Beaubien, Burchill, Gershaw, Hawkins, Hodges, Horner, Howden, Hugessen, King, Leger, Stambaugh, Turgeon and Veniot.—15.

In attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

Dr. Harris Isbell, Director of Research, U.S. Public Health Hospital, Lexington, Kentucky, was heard and questioned by Counsel and members of the Committee.

At 12.30 p.m. the Committee adjourned until Friday, May 27, at 11.00 a.m. in Montreal, P.Q.

City Hall, Montreal, P.Q.,
FRIDAY, May 27, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 11.00 a.m.

Present: The Honourable Senators, Reid, Chairman, Baird, Beaubien, Burchill, Gershaw, Hawkins, Hodges, Horner, Howden, Hugessen, King, Kinley, Leger, Stambaugh, Vaillancourt and Veniot—16.

In attendance: Mr. A. H. Lief, Q.C., Committee Counsel.

Superintendent E. Brakefield-Moore, Acting Officer Commanding "C" Division, R.C.M.P., read a prepared statement and was questioned by Counsel and members of the Committee.

Acting Director of Police T. O. Leggett, Montreal, P.Q., was heard and questioned by Counsel and members of the Committee.

At 12.10 p.m. the Committee adjourned.

At 2.30 p.m. the Committee resumed.

Present: The Honourable Senators, Reid, Chairman; Baird, Beaubien, Burchill, Gershaw, Hawkins, Hodges, Horner, Howden, King, Kinley, Leger, Stambaugh and Vaillancourt—14.

The following read prepared statements and were questioned by Counsel and members of the Committee:—

Inspector Georges Allain, Chief of Detectives, Montreal, P.Q.

Dr. A. W. MacLeod, Member of the Board of Directors, John Howard Society of Quebec, Inc.

Mr. E. V. Shiner, Assistant Executive Director, John Howard Society of Quebec, Inc.

At 4.05 p.m. the Committee adjourned until Monday next, May 30, at 10.30 a.m.

MONDAY, May 30, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators: Reid, Chairman, Baird, Beaubien, Hodges, Horner, King, Stambaugh and Veniot—8.

In Attendance: Mr. A. H. Lief, Q.C., Committee Counsel.

Mr. F. P. Varcoe, Deputy Minister of Justice, was heard and questioned by Counsel and members of the Committee.

At 11.45 a.m. the Committee adjourned until Tuesday, June 7, at 10.30 a.m.

TUESDAY, June 7, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators Reid, Chairman; Baird, Beaubien, Gershaw, Horner, King, Leger, McIntyre and Veniot—9.

In attendance: Mr. A. H. Lief, Q.C., Committee Counsel.

Mr. K. C. Hossick, Chief, Division of Narcotic Control, Dept. of National Health and Welfare, was heard and questioned by members of the Committee.

The following documents, filed by the witness, were ordered to be printed as Appendices to these proceedings:—

Appendix T. Comparison by Provinces of Convictions under the O. & N.D. Act showing Convictions under various Penal Clauses and Length of Sentence awarded. 1945-54.

Appendix U. Scientific Research on Narcotics and its Relation to Traffic in Narcotic Drugs and to Narcotic Law Enforcement and Drug Addiction.

Mr. R. E. Curran, Q.C., Legal Adviser, Dept. of National Health and Welfare, was heard and questioned by members of the Committee.

The following document, filed by the witness, was ordered to be printed as an Appendix to these proceedings:—

Appendix V. Statement by Commissioner H. J. Anslinger, U. S. Bureau of Narcotics, before Senate Judiciary Sub-Committee on Narcotics, June 2, 1955.

The following documents were tabled by Mr. Curran:—

Regulations Nos. 1 to 7, U.S. Bureau of Narcotics.

The following read prepared statements and were questioned by members of the Committee:—

Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries, Dept. of Justice.

Inspector J. J. Atherton, R.C.M.P.

The following tables, filed by Inspector Atherton, were ordered to be printed as Appendices to these proceedings:—

Appendix W. Automotive Traffic entering Canada, July, 1954, and March, 1955.

Appendix X. Ocean-going Commercial Vessels Entering Four Canadian Ports during 1952 and 1953.

A bibliography on drug addiction, referred to by Committee Counsel, was ordered to be printed as Appendix Y to these proceedings.

On Motion of the Honourable Senator Beaubien, it was Resolved to report, as follows:

The Committee recommend that it be authorized to print 800 copies in English and 200 copies in French of its proceedings in blue book form, for distribution as the Committee may direct.

At 12.15 p.m. the Committee adjourned to the call of the Chairman.

MONDAY, June 20, 1955.

Pursuant to adjournment and notice the Special Committee on the Traffic in Narcotic Drugs in Canada met this day at 10.30 a.m.

Present: The Honourable Senators Reid, Chairman; Beaubien, Gershaw, Hawkins, Horner, Howden, and Kinley—7.

In Attendance: Mr. A. H. Lieff, Q.C., Committee Counsel.

The Committee proceeded to the consideration of a draft Report, presented by the Chairman.

Following discussion and amendments, and on motion of the Honourable Senator Howden, the said Report was adopted.

"Drug Addiction", a brief filed by Mr. George Trasov, of Vancouver, B.C., was ordered to be printed as Appendix Z to these proceedings.

At 11.50 a.m. the Committee adjourned to the call of the Chairman.

Attest.

John A. Hinds,
Assistant Chief Clerk of Committees.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

EVIDENCE

OTTAWA, Tuesday, March 15, 1955.

The Special Committee on the narcotic drug traffic met this day at 10.30 a.m.

Senator REID in the Chair.

The CHAIRMAN: Gentlemen, we have a quorum. Will you please come to order. I am sorry there are not more members of the committee in attendance. We have with us this morning Honourable Paul Martin, Minister of National Health and Welfare, who is going to speak to the committee. Without more ado I would ask the honourable minister to open the proceedings.

Hon. Mr. MARTIN: Well, Mr. Chairman, my first words must be words of appreciation for the opportunity of making a preliminary statement in regard to the problem for which this committee has been set up. I hope that what I will have to say this morning will set in perspective at least from our point of view the importance of this problem.

I have a prepared statement here, the text of which I am going to follow closely except for some small interpolations and depending on the convenience of the committee if it would help members I will be glad to distribute the statement so that members of the committee could follow it as I myself deal with it. Would that be your wish Mr. Chairman?

The CHAIRMAN: That would be advisable.

Hon. Mr. MARTIN: While we are waiting to have these texts distributed, which are here, perhaps you will allow me to table for the committee a copy of each one of the following measures:

- Opium and Narcotic Laws of the United States,
- The Dangerous Drugs Act for the United Kingdom,
- The Mental Hygiene Act, Saskatchewan,
- The Narcotic Drug Addicts Act, Manitoba,
- The Mental Hospitals Act, Ontario,
- The Private Sanatoria Act, Ontario,
- The Psychiatric Hospitals Act, Ontario,
- The Provincial Hospital Act, New Brunswick,
- The Narcotic Drug Addicts Act, Nova Scotia,
- The Mental Diseases Act, Alberta.

The CHAIRMAN: I wonder, Mr. Minister, if it will be advisable for copies of these statutes to be given to each of the members. I think it might be advisable to have copies in the hands of the members.

Hon. Mr. MARTIN: I have no copies of these acts with me. I am just tabling them here. Mr. Curran of our Legal Division will be glad to assist you, but I am sure that some time in your proceedings you will want to see these measures and I thought I would formally put them on the table at this time.

I may say Mr. Chairman that when this committee was set up I at once advised the Leader of the Government in the Senate (Hon. Mr. Macdonald) and when you were selected as Chairman I advised you as well that the

officers of my department were at your disposal and that I had especially designated Mr. R. E. Curran, the senior solicitor in our department to act as the liaison between the department, yourself and the committee, and also I wish to take this opportunity of assuring you of the desire of our department and myself as its minister to co-operate in any way we can in a work which I believe to be of the utmost importance.

The CHAIRMAN: We appreciate that very much indeed, Mr. Minister.

Hon. Mr. MARTIN: Perhaps I could now continue with my statement.

Responsibility under Opium and Narcotic Drug Act

My responsibility as the Minister of National Health and Welfare for the administration of the Opium and Narcotic Drug Act makes it appropriate to say something to the committee respecting Canada's drug problem as it is known to us from our experience in dealing with it.

In addition to my official responsibility under the Act, I have taken a very deep interest in the subject of narcotic drug control and have personally visited the large narcotic treatment centre at Lexington, Kentucky, in order to obtain first-hand information respecting methods of dealing with addicted persons.

From the very wide experience which has been gained in connection with the administration of the Act, together with a personal interest in the subject, it is hoped that a statement to the committee will be both informative and helpful in connection with its deliberations.

Value of Enquiry

With the amount of publicity that has been given in recent months to the drug traffic at the west coast, and the suggestion that it is a problem of alarming and increasing proportions affecting the youth of our country, it is most appropriate that it should be subjected to a sober, factual and objective examination, by such a committee as has been set up.

For these reasons I very warmly welcome the committee, and I venture to suggest that you will be rendering Canada a great public service by the deliberations which are beginning this morning; and I am sure that its members will be rewarded because of the importance of the facts to be brought out.

The enquiry which this committee proposes to make into the drug traffic and problems connected with it should, therefore, be of the utmost value in putting the situation into focus as regards size, subject matter, geographical incidence as well as the jurisdictional responsibilities which it involves.

The report of this committee will be eagerly awaited by those of us who are concerned with the administration and the enforcement of the law and by the people of Canada generally. An examination of this problem would therefore seem most timely and I have every confidence that the Committee will do a thorough and competent job.

I venture to suggest that there is now before Parliament no more important committee than the one whose deliberations are now taking place.

Legislation: Narcotic drugs provide one of the most effective and powerful weapons known to medical science in its fight against pain and suffering. But because of their very effectiveness they have a great potential for evil if improperly employed.

In 1908—some 47 years ago—in recognition of this danger, Canada enacted the Opium and Narcotic Drug Act. This law, with amendments made from time to time on the basis of need and experience, compares most favourably we believe with any legislation that has been enacted in any country to deal with narcotic drugs. It provides all of the administrative flexibility that can be

desired in insuring that narcotic drugs will be available for legitimate medical and scientific needs, together with effective restrictions against trafficking and illegal possession.

It does not define precisely what is considered to be legitimate medical and scientific use as these are matters which must properly be left to the professional interpretation and discretion of medical people.

Indirectly, through its prohibitions and penalties, it does identify a number of matters which are not considered to come within legitimate medical and scientific use.

The two most important of these are the use of drugs in other than medical treatment for a medical condition, and the distribution of drugs except under the legal machinery of the law.

The legislation accordingly has two distinct aspects. The first provides the administrative machinery whereby narcotic drugs are brought into Canada and are made available for medical and scientific purposes through legitimate trade and professional channels. The second is the enforcement side. Although this affects but a relatively small number of people in our country, it unfortunately is the part of the Act which the public are prone to think is its only purpose.

When the amendments to the Act were under consideration a year ago, the question arose as to whether the time had not arrived to revise the legislation. After discussion of this with the R.C.M. Police, with whom we must be in continuous consultation, it was decided to proceed with certain amendments which were considered essential as regards new offences and increased penalties and on the basis of experience of a year or so with those amendments, coupled with any information which might emerge from the British Columbia survey, the legislation would be reviewed. I am glad that the revision was delayed because when we do come to revise the Act, as we will, it will be possible to reflect in the revision the conclusions that will have been reached by this committee insofar as they relate to matters which are within federal responsibility.

I should just say by way of parenthesis here that last year we amended the Act. We increased the penalties. The bill to amend the Act was introduced in the Senate and was adopted later without amendment in the House of Commons.

United Nations: I should like to say something respecting the international control of narcotic drugs. Canada is a signatory to all of the international conventions which are designed to limit to medical and scientific uses narcotic substances, including the protocol by which the signatories agreed to limit to that purpose the production of opium. In accordance with the obligations under the conventions, Canada estimates yearly the amounts of narcotic drugs that will be required for medical and scientific use and only imports amounts in accordance with the estimates. The legislation which Canada has enacted conforms in all respects with the requirements of the conventions and I think it is only fair to say again that our legislation is considered to be as realistic and effective as the legislation of any country for this purpose. But it may be that as the Minister in charge of this matter I am prejudiced and I would welcome the objective consideration of this committee. I shall not assume that everything we are doing is correct; but I do believe our legislation deserves the appraisalment that I have given it.

To conclude the international picture, Canada has been a member of the Opium Advisory Committee since its establishment as a committee of the League of Nations. With the establishment of the United Nations there was set up to succeed this committee a committee known as the Commission on Narcotic Drugs. Canada is also a member of this Commission and a record

of the deliberation of the League of Nations Committee and the Narcotic Commission will reflect the part that Canada has played in international control and the very high prestige which this country enjoys for its work in attempting to bring about the kind of international agreement which will help to reduce the problems resulting from illicit importation and use of narcotic drugs.

Previous Statements: I have spoken in the House of Commons on a number of occasions concerning Canada's drug problem. The last occasion was almost a year ago when the Opium and Narcotic Drug Act was amended (*Hansard*, House of Commons Debates Vol. 96, No. 119, p. 5314). Without adding unduly to what is already a matter of record, it may be helpful to recapitulate some of the things that can be said respecting the drug traffic and its victims, the drug addicts.

Traffic: The Honourable Senators who will have looked at the amendments to the Opium and Narcotic Drug Act will see that traffic is defined in the Act to mean all dealings in narcotic substances other than by licensed or authorized persons. In other words, the definition of trafficking is intended to refer to the illicit distribution of narcotic drugs.

By administrative arrangement, the R.C.M. Police are responsible for the enforcement of the criminal side of the legislation and my Department is responsible for those things which relate to the importation and the legal distribution of drugs in Canada.

This is perhaps something of an over-simplification but it is a convenient method of separating the administrative and the enforcement sides of the law.

Obviously, the officers of my Department who are concerned with the subject, work closely with the R.C.M. Police and particularly as the subject of trafficking is involved.

Undoubtedly representatives of the R.C.M. Police who will appear before this committee will explain something of the traffic in drugs in Canada. I would not wish, therefore, to presume to explain in any detail, how this evil distribution operates.

Because of the supervision and control that is maintained over the legal importation and distribution of drugs in Canada, little if any of our legal supplies finds its way into the illicit market. The supplies which are available in the illicit market are smuggled into Canada by persons who are in the drug traffic.

The drug traffic, as will be explained by the R.C.M. Police is comprised of a variety of persons, from the individual who negotiates for the supply of drugs which he may not handle personally, to the street peddler, or pusher, as he is called, who is in direct contact with the addict population.

In talking about traffickers, the public are prone to think of the vice czar and not to include in this evil the peddler, or pusher, through whom the drugs reach the addict population.

I should point out, however, that trafficking in drugs means the illicit distribution of drugs, whether by an individual who deals in larger quantities, or by the peddler who perhaps caters only to a local and limited number of addicts. Peddlers generally are themselves addicted to drugs. It is sometimes difficult, therefore, to draw legal distinctions between peddlers and their victims. The peddler who is, of course, a trafficker in a small way, is frequently his own victim and his victim may and usually will be, a small-time trafficker if the opportunity presents itself. I will have something more to say respecting this feature in talking about the incentive to trafficking.

The victim of the peddler is often looked upon with a degree of sympathy and compassion, but this cannot always be reconciled with his alternative role of peddler, to say nothing of his usual criminal record or background.

Profit:

The incentive to traffic in drugs is either profit or the need for drugs. The profit to be derived from illicit distribution is extremely high as the following figures will serve to illustrate.

An ounce of heroin, which incidentally is not a drug that can any longer be legally imported into Canada, costs approximately \$12.00 wholesale. I may say that last year we banned heroin from coming into Canada for any purpose.

The illicit price for a capsule of heroin containing one-quarter grain will range from \$3.00 to \$5.00 depending upon the average illicit supplies, or a total illicit price per ounce from \$5,200 to \$8,700. Depending upon the extent to which the drug may be adulterated by the addition of other substances, the price can greatly exceed these figures. There is, thus, a heavy profit incentive for traffickers to engage in the illicit distribution of drugs.

This includes the individual who is responsible for the smuggling of drugs into Canada, as well as the peddler who directly caters to addicted persons.

We arrived at the profit figure which I have just referred to in the following manner. For practical purposes an average narcotic dose is computed to contain one-quarter of a grain of heroin, and as there are 437½ grains in an ounce, this would yield 1,750 doses. With a capsule containing this dosage, selling at anywhere from \$3 to \$5, it will be seen that the total price that an ounce is capable of producing is from \$5,200 to \$8,700. Further, I should point out when I say there is one-quarter grain of heroin in a dose, that it very often happens the drug will have been diluted so that a one-grain capsule will contain even less than one-quarter of a grain of pure substance.

The other incentive to trafficking is the need of an addict to have supplies available for his own use. With the heavy cost of drugs in the illicit market, his daily requirements are often beyond his financial reach. He accordingly will become a small trafficker and from the profit that is available to him, either in cash or through adulteration of the drugs which he handles, will manage to secure for himself enough for his own needs. These are some of the people against whom the penal side of the legislation is directly aimed. The elimination of distribution at any level, reduces by so much the availability of drug supplies to the addict population of Canada.

I hope that it is clear to the members of the committee that it is not always possible to make a simple and convenient division between drug traffickers and addicts. If there were no drug addicts then there would be no drug traffickers. It does not follow, however, that if there were no drug traffickers there would be no addicts because it is the demand by addicts which creates the traffic. The problem, therefore, cannot be examined wholly in relation to the traffic, but must also be considered in terms of the persons upon whom the traffic depends.

This might be a convenient point at which to digress momentarily and put on the record the drugs of addiction. "Narcotic drugs" are listed in the schedule to the act. Reference to the schedule at the end of the act will give you the schedule of drugs which we regard as problems so defined.

Barbiturates are not narcotic drugs. They are covered, in so far as use is concerned, under the Food and Drugs Act.

The drugs that are listed in our Opium and Narcotic Drug Act come either from natural sources or are synthetic. The natural drugs come from opium, coca leaf or hemp. Opium produces morphine, heroin and codeine the principal drugs in use. Coca leaf produces cocaine and hemp produces cannabis sativa.

Of all these drugs heroin is the one that is the most commonly employed for addiction in Canada. Marijuana, which produces cannabis sativa is not a drug commonly used for addiction in Canada but it is used in the United States and also in the United Kingdom by addicts. Members of the committee will at one time want to go into the question of synthetic drugs and in this connection I should point out that the synthetic drugs of which demerol would be an illustration are not commonly used in the illicit market. This undoubtedly is due to the strict controls which are kept over our legal supplies. Occasionally synthetic drugs will be found on addicts but it can be said that the synthetic drugs do not constitute any important part of our traffic. This is interesting to me, because a number of years ago I went on a raid in New York City with the internal revenue officers of the United States Government, and, of the number of individuals that were picked up, at least two of eight were in possession and were actually using synthetic drugs.

Addiction Situation in Canada: Having commented briefly upon the traffic in drugs, the honourable senators will, I am sure, wish to hear something about our addiction problem which, as I have mentioned, supports the illicit traffic.

As I said in discussing the amendments to the Opium and Narcotic Drug Act, there is a great deal of confusion and misunderstanding respecting the kind of people who are addicted, their motivations and what can be done to help them. Expert witnesses will be available to you and will appear before this committee, I am sure, prepared to explain the medical aspects that are involved in drug addiction as well as in any treatment of that condition. I do not propose therefore, to discuss this morning questions of motivation and other matters which I think should properly be left to more qualified witnesses than I. I think, however, it would be helpful to the committee if I said something about the size of our drug problem in Canada as it is known to us through the statistical and other information which we have in the department.

I am sure, Mr. Chairman, you, as a former parliamentary assistant to myself as Minister of National Health and Welfare, are familiar with our work in the department and particularly with our statistical records which, I understand, you saw again yesterday, and I am sure that all of those facilities will be available to members of your committee if at any time you should wish to visit the department and that particular branch.

In speaking to the amendments to the Opium and Narcotic Drug Act a year ago, I stated that the number of addicts in Canada was estimated to be slightly in excess of 3,000. Perhaps you will want to compare this figure with the estimated figure of 65,000 drug addicts in the United States. I should like to explain to the committee the basis on which our estimate was made and to give the members some statistical information which we have had prepared on this subject. Medically speaking, a drug addict would be anyone who, for any cause, has acquired a physical or mental dependence upon narcotic drugs. For administrative purposes, however, drug addicts are usually divided into three classifications. There is, first, the individual who has or has had some medical condition requiring narcotic administration which has resulted in his addiction to narcotic drugs. There is secondly, the group comprising certain professional persons who have become addicted to drugs.

As a rule, none of the persons in these groups patronize the illicit market. Those in the first group will generally be under medical supervision and do not present any acute problem to the enforcement authorities. The persons in the second group can, as a rule, be dealt with administratively. The third group, and this is the group which I think comprises the problem which has brought about the need for this investigation, is made up of persons who are addicted to drugs and who obtain their supplies in the illicit market. These persons are often called "criminal addicts" for the reason that this group patronizes the illicit market and supports the traffic.

Mr. Hossick, who is the Chief of our Division of Narcotic Control will undoubtedly appear before this committee and I am glad to take this opportunity of commending the great work which he and his associates in our department do. He will explain to you the administration of the act and the very extensive and meticulous records which are maintained in his division, involving not only the legal importation and distribution of drugs in Canada but persons to whom drugs are administered or made available. In addition to this type of information he also has records of the persons in Canada who are known to be addicted, their habits having come to the attention of the enforcement authorities. I need not, of course, say at this time that we will under no circumstances make public the names of those individuals to this committee or any one else. You are not interested in the names or identification, you are interested in the problem and the statistics.

The records which Mr. Hossick has in his division and which are kept up to date in co-operation with the R.C.M. Police and other enforcement agencies, we think are as complete and accurate as it is possible to have, considering the kind of people that are concerned, but even with this mass of statistical information it is impossible, as you will readily understand, to take an accurate census of our addict population. I need not elaborate on all of the reasons why an accurate census is not a feasible thing to suggest, as I am sure that these reasons will be apparent to the honourable senators. I wish, however, to point out that, on the basis of the information that we do have, we consider it possible to compute with some degree of accuracy the size and extent of our drug addiction problem.

On the basis of the information which we have I have prepared summaries which I propose to table for the convenience of this committee. I do not have copies of these tables but they will be on the record and available for your careful scrutiny.

The first table (*see Appendix A*) that I would like to present Mr. Chairman, is one which sets forth a breakdown of the total size of our addict population under the three classifications which I have explained. This table shows criminal addicts at 2,364; medical addicts, 515; professional addicts, 333. This adds up to a grand total of 3,212.

That table shows, for instance, that in British Columbia there are 1,101 criminal addicts at the moment, as compared with 655 in Ontario and 260 in Quebec. I will not comment further on the figures, which will be available for your further consideration.

Tables 2 and 3 (*see Appendices B and C*) are concerned with addicts who are in the third group, namely, criminal addicts. This gives information respecting the numerical size of the group by age and sex. According to this information, there are 1,708 male addicts and 656 female addicts in this group. The tables also give some helpful information on occupations, marital status and other data which the committee may find of interest.

As regards the size of our drug addict population, I would like to say that, while the number I have given, or for that matter any number of drug addicts, is serious and distressing, the total number must be viewed in terms of Canada's total population which is well over 15,000,000 persons. The committee will undoubtedly hear a great deal of evidence on the numerical size of the problem and I hope that the tables which I have produced, prepared from the information which we have and believe to be accurate, will be helpful. I wish to say something in connection with this problem.

Age Groups and Teen-Age Problem: A great deal has been said about the youth of Canada being exposed to drug addiction and it has been suggested that we have in this country a teen-age addiction problem. It is suggested that children of high school age who are attending school are being recruited

into the addict ranks either by traffickers or by other juvenile addicts. I can say with my authority as Minister in charge of this department; that we have no such problem in this country and that our high schools are definitely not sources of drug addiction. I would point out that, of the 2,364 known criminal addicts, the records show that 26 only are under the age of 20 years. Of these, 7 are male and 19 are female. These young people, however, were not attending school when they became involved in this traffic and were already known to the police for juvenile delinquency in one form or another.

Undoubtedly some of the members of this committee will be wondering about reports which appeared in the press a year or so ago regarding a so-called teen-age addiction problem in the city of Vancouver. The young people who were implicated at that time are part of the group to which I have just had reference and I am reliably informed that, with one exception, all of this group were previously known as juvenile delinquents. Even the one who had no such record had left school and was reported as being a problem child to her parents. I think I have said enough to indicate that we have no addiction problem among teen-age high school students in Canada.

It is only fair that this should be emphasized, because press reports have gone out into other countries about the nature of our school system, including our high schools.

Senator QUINN: May I ask here, Mr. Minister, is there any particular reason for the considerable difference between the number of male addicts—seven—and of female addicts—nineteen—under the age of twenty?

Hon. Mr. MARTIN: I don't think we can offer any particular reason for these comparative figures.

Senator HOWDEN: Females are more susceptible.

Hon. Mr. MARTIN: Geographical Distribution: The tables which I have produced do not break down as between cities the actual geographical distribution of our addict population. I think, however, that it will be apparent from all that has been reported on the subject that the majority of the addicts—not only numerically but on a per capita basis—are located in the City of Vancouver, with the remainder located in other large urban centres.

The total drug addict population in the Atlantic Provinces is under 15. As to the City of Montreal, which is the largest city of Canada and a centre where a substantial number of addicts might be expected to be located, I can report that, according to the figures available to us, the total criminal addict population in the entire province of Quebec at the present time is well under 300.

The traffic and addiction are frequently identified with our oriental population. I think it proper to say something with respect to this suggestion. Many years ago opium was smuggled into Canada for use by orientals in smoking—a habit that had been brought to this country from their own lands. Incidentally, the first legislation that we had in Canada was aimed primarily at the suppression of the traffic in opium. The smoking of opium has now virtually disappeared in Canada and while we do have a very small number of oriental addicts, the number is so small as to support the statement that addiction is not a problem in Canada that is properly identifiable now with our oriental population. I think they are to be given great credit for this fact.

It has often been suggested that the incidence of addiction at the City of Vancouver is attributable to it being a seaport and that drugs which reach that centre are brought in directly from the Orient. I think I might say, however, that there is no evidence to identify the problem in Vancouver with the fact that it is a seaport or to support the belief that the drugs which reach that city enter directly from the Orient. The general trend of distribution seems to be

from the East to the West and the evidence suggests that drugs supply a need and will go wherever the market happens to be. At the moment, the market happens to be at Vancouver but experience has shown that this could shift to another part of Canada. There is no evidence of a drug traffic problem in any rural part of Canada.

Convictions: A perusal of press and other reports would indicate an alarming increase in our drug problem. It has been suggested that the traffic shows a steady increase as evidenced by the number of arrests. Let us see what the facts really are. There is no question but that, with the vigorous enforcement of the law which is being exercised by the R.C.M. Police and by local police agencies, the number of arrests is a barometer which indicates an increase or decrease in the size of the problem. It may therefore be interesting to the committee if I place on record some statistical information respecting convictions under the Opium and Narcotic Drug Act. This information will, of course, be given in greater detail to the committee by other witnesses, whom I suggest you call, but meanwhile I wish to indicate sufficient only to show something of the trends as they may be reflected by the number of convictions.

In 1952 there were a total of 371 persons convicted of narcotic offences; in 1953 this number had increased to 402, but I am glad to be able to say that for the year 1954 the number was reduced to 349, which is the lowest figure since 1950.

It may be of interest at this point to speak specifically with respect to the situation in the Province of British Columbia. In 1951 there were 205 convictions in the province; in 1952 there were 242, and in 1953 the number rose to 265. Again, I am glad to say that in 1954 the number was reduced to 192, again the lowest figure since 1950.

I might point out, in passing, that until 1954 our figures on convictions were based on the judicial year ending September 30; since 1954, to provide for uniform reporting to the United Nations, they have been based on the calendar year. The R.C.M. Police figures, however, are compiled on a fiscal year basis for reporting to Parliament.

I would not suggest that the record of convictions is the only index for the increase or decrease of our narcotic problem. I do suggest, however, that these figures are revealing when contrasted with the amount of publicity which is given to the problem as one of increasing and alarming proportions.

I would not want anyone to think that either the Department or the Government is not anxious to deal as effectively as possible with the problem to the extent to which I have projected its proportions this morning.

Jurisdictional Responsibilities: The next matter that I wish to touch upon deals with the jurisdictional areas that are involved in our drug problem, and it is a matter you will want to have clearly in your mind in the assessment of the situation.

There is frequently a tendency to identify the Opium and Narcotic Drug Act with not only the drug traffic but also with drug addiction. It is necessary, therefore, to make some distinction between the measures which the Federal Government may properly undertake by its legislation and the measures which constitutionally are regarded as being of provincial concern.

The control of the importation and distribution of drugs and the suppression of illicit distribution and use come within the responsibility of the Federal Government. The treatment of illness, however, is a matter which comes within provincial responsibility and inasmuch as drug addiction as such is considered by medical and social authorities as a form of illness, the rehabilitation and treatment of drug addicts is a matter which is of provincial concern.

Just as much as any other illness is a matter primarily of provincial constitutional responsibility, so is this particular problem in respect of the aspects which I am just now treating.

The Opium and Narcotic Drug Act makes it an offence to be in possession of drugs except under lawful authority. It does not, however, purport to make it an offence to be addicted to drugs. The implications of assuming jurisdiction over addicted persons by attempting to make addiction a crime are such as will need no elaboration. The essential right of the necessary legal custody and control over the addict for the purpose of treatment is therefore something which would require appropriate provincial legislation. Whatever you may think of the situation constitutionally and whatever you may think should be the situation, the fact is there can be no question that under the constitution this aspect of the problem, as it involves a matter of property and civil rights, comes within the competence alone of provincial governments. Some of the provinces have recognized this by the legislation, which I have already tabled, that has been enacted to deal with the treatment of drug addicts.

The Federal Government has gone on record with all of the provinces in clarifying the distinction which I have made to you and has offered to assist in any way that it can, within the limits of its authority and responsibility, in helping to find a solution to the problem of drug addiction. I shall have something further to say with respect to this in discussing treatment proposals.

Treatment Proposals: While the treatment of drug addicts may not fall squarely within the terms of reference of this committee, the Government Leader in the Senate who introduced the motion stated that it was hoped that the examination would be sufficiently broad to permit of recommendations to the Federal Government with respect to matters within its responsibility, and suggestions which might be of assistance to provincial governments with respect to matters within the responsibility of those governments.

I certainly would hope that you would consider it to be within your terms of reference to give consideration to the wider aspect of the problem. You may even want to consider your authority in asking for the collaboration in your work by provincial governments. You may even want to give consideration, Mr. Chairman—and I merely offer it as a suggestion—to inviting certain provincial governments actually to take part as witnesses before this committee in an effort to try and put this problem on its remedial side in its truest perspective. I think, therefore, that it may be helpful if I say something of the various proposals which have from time to time been made respecting measures for the treatment of drug addicts. Before doing so I wish to say a word respecting a study which is presently being made in the Vancouver area with federal support.

It is a study that is being paid for in its entirety under the national health program provided for by the Department of National Health and Welfare and the Federal Government.

Some two and a half years ago, the federal authorities suggested to the provincial health authorities in the Province of British Columbia, the desirability of a conference to discuss the drug problem at which municipal authorities and other interested groups might be present.

The conference took place, and arising out of its discussions, the suggestion was made that a study should be conducted in the Province of British Columbia regarding the drug problem in that area, and particularly as it affected drug addicts.

Eventually Dr. G. H. Stevenson, an eminent psychiatrist, was selected to head up this study and a project was submitted by the Provincial Government under the National Health Program for federal financial assistance to carry out this study. The study, which is being financed by the Federal Government

will, when completed, provide much needed information regarding drug addiction in the Vancouver area. Its conclusion can undoubtedly be incorporated with what you are doing in this committee. From this study it is hoped that proposals may lead towards more adequate remedial measures than are presently available.

Meanwhile I can say something of various suggestions which have so far been advanced, ranging all the way from permanent detention for drug addicts to the provision of free drugs to them.

The members of this Committee will undoubtedly be aware of a study which was made by the committee on Addiction of the Vancouver Community Chest and Council into the drug problem in Vancouver. This committee, following its examination, made a report which contained a number of recommendations. Amongst these recommendations were the following:

1. Amendments to the Opium and Narcotic Drug Act to permit of a distinction between traffickers and addicts;

2. The establishment of treatment and rehabilitation facilities for addicts;

3. The modification of the Opium and Narcotic Drug Act to permit the establishment of narcotic clinics where registered addicts might legally receive narcotic drugs in minimum required dosages.

As to the first recommendation, the Honourable Senators will recall that the amendments made to the Opium and Narcotic Drug Act at the last session were intended among other things to permit of a distinction being drawn between the trafficker and an addict in terms of the penalties which might be considered appropriate.

These amendments were first introduced in the Senate and referred to the Standing Committee on Public Health and Welfare. Following careful consideration of the legislation, the committee recommended the adoption of the amendments which were in due course passed in the Senate and afterwards in the House of Commons.

I do not think I need elaborate further on the result of this first recommendation beyond saying that substantial effect has already been given to what is involved in it.

The second proposal involves facilities for the treatment and rehabilitation of drug addicts. This is a matter which for reasons I have already mentioned, comes within provincial responsibility.

Last fall, in response to a proposal by the Attorney-General of British Columbia, I advised that the Federal Government would be very glad to participate in any Conference that might be arranged to discuss the treatment of drug addiction, but at the same time, I drew his attention to the jurisdictional questions involved in the subject.

As evidence of our interest in the problem, I offered under date of December 3, to make available to the Province of British Columbia our quarantine station at William Head on Vancouver Island for use by the province as a treatment centre. I also indicated that the Government would be prepared, under the National Health Program, to examine a project by the province to see if financial assistance might be given for the renovation of the premises to make them more suitable for that purpose.

I have not heard from the Attorney-General with respect to this offer, but I do observe in the Speech from the Throne delivered on January 25th at the opening of the Legislature in British Columbia, the following statement:

My government plans to implement an experimental program for the treatment of narcotic addicts.

I do not know whether this has any reference to the proposal which I made, but my offer was one designed to assist the provincial authorities in finding a solution to that part of the problem which is within their responsibility.

Ontario Treatment Plan:

The Honourable Senators may have heard recently of a proposal respecting treatment facilities in the Province of Ontario. I am not able to say a great deal with respect to this beyond the fact that Dr. Van Nostrand, who has recently been appointed psychiatrist to the Ontario Reform System, has stated that he proposes to take a very special interest in the problems relating to the treatment of drug addiction. I have made direct inquiry of the provincial authorities for further information in this regard but up to the present time nothing has been furnished to us.

Lexington: Now, last summer I visited the most outstanding and most important treatment centre of this kind in the United States, or for that matter in the world, and I want to give you some of the important impressions which I gained from my visit to this institution, which is operated by the United States Public Health Service at Lexington, Kentucky. The institution is extremely large and is most impressively equipped and operated. It has, as I recall, a capacity of some 1,300 addicts, in addition to the necessary medical, custodial and other staff. It accommodates both male and female addicts.

It has the latest and most up to date hospital facilities, as well as all facilities for research either of a medical or statistical character. It has very elaborate occupational and vocational facilities, which range from farming to fine cabinet making.

The CHAIRMAN: May I ask if the patients go there voluntarily?

Hon. Mr. MARTIN: Most of the patients are there by court order. That is very important, and I am coming to it in a moment.

It is not necessary for me to outline the treatment procedures which are followed at this institution but I was very much impressed with the amount of psychiatric and other counselling service which, along with occupational and vocational therapy, was apparent in their treatment program.

I may digress by saying that the Superintendent is a Dr. Lowry, and in accordance with the tradition of the Public Health Service of the United States, he is technically a member of the armed services. I was a guest at his house, which is located in the beautiful hills of Kentucky, in the vicinity of the hospital, and I cannot speak too highly of the hospitality which he extended to me and the information he gave to me and also to Dr. Roberts, head of our Mental Health Division in the Department of Health and Welfare, who accompanied me. I would suggest that some time it might be found desirable, Mr. Chairman, to invite Dr. Lowry to come here as one of your witnesses.

Senator GERSHAW: To what extent do they find that there is a departure from normal, mentally, as well as drug addiction in those particular cases?

Hon. Mr. MARTIN: I wonder if you would very kindly allow me to complete the statement I intend to make, so that there may be as much sequence as possible?

Senator GERSHAW: Certainly.

Hon. Mr. MARTIN: There were pointed out to me by the Lexington authorities two matters which seem worthy of careful consideration should any provincial authority in Canada contemplate the establishment of treatment facilities.

The first of these involves the method of admission to the institution and the second the degree of follow-up, including supervision and job placement on discharge.

The admission to the Lexington institution is essentially through the courts following a conviction of an addicted person for either a narcotic or another offence.

I think that was the point you made, Mr. Chairman.

The CHAIRMAN: Yes.

Hon. Mr. MARTIN: In addition to this form of admission, patients are also admitted on a voluntary basis. I understand that the authorities are endeavouring to increase the number of voluntary admissions.

My memory is that roughly 20 per cent of the addict population in this hospital were voluntary patients, the great majority there being by court order.

It is pointed out, however, by experienced authorities that, while the voluntary system is admirable in that patients who desire to be treated are able to gain admission before they run foul of the law, it presents a problem in maintaining custodial control over the period of time which is necessary for their complete treatment.

For instance, I recall meeting a doctor who was himself a voluntary patient. This man, a very distinguished medical doctor from one of the larger states, talked quite frankly about his problem and told me that he was there for the second time. He said further that his first visit had been for only seven months, and because of important professional work he felt he could not stay longer; however, he added, had he stayed longer he would not have had to come back a second time.

Senator HODGES: Mr. Minister, may I ask how long an interval of time elapsed between the first and second visits?

Hon. Mr. MARTIN: About three years.

It is therefore pointed out that a desirable system should feature the advantages of the voluntary admission system, but at the same time would have the legal right to the control and custody of the patient for such time as the authorities feel is necessary, both during the time of treatment and in the post-discharge period. It was in this connection that I mentioned the need for appropriate provincial legislation.

The other feature which merits consideration involves a job placement service with a follow-up and supervision by experienced authorities not only to determine the degree of success which attends treatment in the institution but also to provide a very necessary support to these persons during their very difficult period of readjustment on discharge.

In drawing attention to these two factors I would point out again that the authorities in the United States who are in charge of this great operation are very much aware of these needs and these were amongst features which were given particular emphasis as requiring consideration in the establishment of any treatment program.

There are two other similar institutions in the United States, one in New York City and the other in Fort Worth, Texas. The one in New York, which is the only one of these two which I have visited, is concerned with juvenile addicts. The cost of these institutions is tremendous, and is a factor, though not the governing factor, that should be related to the extent to which the follow-up is really a successful endeavour. However, I may say that before I visited this institution in New York, on the advice I had been given and the impression I received from others who visited the institution, I doubted very much—in fact I said so in the House of Commons at one time—that it was an experiment to which we should be pledged. But, after my visit to the Lexington and New York institutions, I cannot but feel that it is deserving of very considerable and careful study by the provincial authorities in this country, and by us to the extent that it is within our terms of reference and power.

I would not wish to say anything further with respect to treatment measures for narcotic addicts as undoubtedly there will appear before this committee many qualified experts in this area.

Legal Distribution to Registered Addicts: The third proposal made in the Vancouver brief is perhaps the most controversial proposal that has been made in connection with a treatment program. I do not propose to go into the implications of this in detail because I see that Dr. Stevenson, to whom I have already referred, has published in the January issue of *The Bulletin* an article entitled "Arguments for and against the Legal Sale of Narcotics". In this article, Dr. Stevenson deals adequately and exhaustively with this proposal and I would only add to what he convincingly sets forth that enforcement authorities in Canada and the United States are unanimously opposed to any plan involving free drugs to registered addicts for self-administration.

Senator HOWDEN: Hear, hear.

Hon. Mr. MARTIN: This is the stand I have taken in my discussion of the matter in the House of Commons, and it is the stand I take very strongly today.

Perhaps Dr. Stevenson, if he appears before this committee, will wish to explain a further proposal which I understand he has made involving the withdrawal of addicts in general hospitals followed by a specialized rehabilitation program. A proposal for the treatment of addicts under an approved plan, which as part of it would require the administration of narcotic drugs under medical supervision, would not involve any change in the existing law. The provision, however, of drugs to compete with the illicit traffic is not, in my view, proper treatment and is not a matter that I, speaking as a minister and member of the government, could support. Apart from these reasons, there is the additional question of our international commitments by which we have agreed to limit narcotic drugs to medical and scientific use. It is highly doubtful if the provision of drugs to addicts could be said to come within such use.

There seems to be a wrong impression abroad in Canada as to the medical and scientific use of drugs, and perhaps I may be at fault for not having corrected it; however, I tried to do so in the discussions we had in the House of Commons last June.

This might be a convenient point at which to reiterate that there is nothing in the laws of Canada at the present time which in any way limit a doctor in his use of drugs in the treatment of his patients. That is to say, theoretically, there is no limit to the use of drugs under doctor's orders. That does not mean to say that when a doctor prescribes drugs we do not carefully note the amount of the drugs and their need under the circumstances. If a doctor is honourably employing certain drugs in his practice, there is nothing in the act which limits the amount he may make available to a patient.

The CHAIRMAN: For the purposes of clarification may I ask this question? Would the putting into effect of a system of free drugs violate Canada's obligations under the United Nations?

Hon. Mr. MARTIN: Yes.

Senator HOWDEN: But you cannot cut off an addict's drug supply suddenly; it just can't be done.

Hon Mr. MARTIN: That is not quite the point the Chairman was making and the one to which I directed my answer. You will note the latter part of the last sentence I read from my text uses these words, "... there is the additional question of our international commitments by which we have agreed to limit narcotic drugs to medical and scientific use."

However, the statement I made a few moments ago is an important one, because it is often suggested that the treatment method in Canada and in the United States differs from that in the United Kingdom. What I have said is that under our law there is nothing which denies to a doctor the right to administer a drug in quantities which he believes desirable for a particular patient. We have found the medical profession to be an honourable body and one which, for the most part, observes this rule. We have doctors say that they are providing drugs to a patient and that that patient required those drugs. So long as he exercises those powers in accordance with his code of ethics and in the proper professional care of his patients, there is nothing in the law which limits the doctor's prescriptive powers.

There is a further suggestion which has been advanced but is not one made in the report which I have referred to. It is, however, one that has been put forth by many experienced enforcement authorities as offering the most practicable and realistic approach to the solution of the drug addict. This involves the establishment of treatment institutions with legal authority for the committal and detention of addicts for such period as is necessary for their treatment and rehabilitation. In Lexington it is felt that they could not possibly carry out their work unless the addict is within the control of the institution for a definite period. Even there they complain that their control is not great enough. It would require of course the legal right to return to such institution an addict who had been released on discharge which, in turn, recognizes that a certain number of addicted persons might be more or less permanent inmates in that little hope could be held out for their successful treatment.

A close study of the operation of the treatment centre at Lexington, Kentucky, is strongly recommended to this committee. Incidentally, I should point out that the Lexington institution would appear to be a very costly operation because of its size and the very elaborate facilities as well as the staff which is required.

Now, the question may arise as to whether, if this is a proposal recommended by enforcement authorities, the Federal Government should not undertake it, and I am confronted with that suggestion constantly. I have to point out however that there is no legal authority for the Federal Government, under our constitution, to enact the kind of legislation requiring the compulsory committal and detention of drug addicts while undergoing treatment. That is a matter that constitutionally is regarded as coming within the property and civil rights clause of the enumerated sections of the British North America Act giving exclusive power to provinces. We therefore, would have no power to exercise this kind of control. This is a matter with which only the provinces could deal for the reasons which I have previously referred to in discussing the jurisdictional aspects of the problem.

It is pointed out by the authorities that the compulsory committal of drug addicts either upon their own application or upon the application of interested friends or relatives would effectually remove them from access to the illicit market and would thus bring about a reduction and eventual elimination of the traffic. Perhaps others who will appear before the committee will wish to say something with respect to the operation of such a plan. I thought I should refer to it so as to give the committee the benefit of a brief review of various proposals which have from time to time been made and urged on us by people who are interested in this problem.

United Kingdom: I gave as the total addict population of Canada the estimate of 3,000. You will find that the number of drug addicts reported to be in existence in the United Kingdom is approximately 300 and in France is

about 700. It would not be proper for me as a member of the Government to make detailed comment on those figures but I simply find it difficult to accept them and I do hope you will go into this aspect of the problem.

You will find, I am sure, during your investigation some reference to the British Treatment plan as constituting something that Canada should adopt. I would refer you to an article by Dr. G. H. Stevenson in the January issue of *The Bulletin* to which I have already referred. In that article Dr. Stevenson discusses informatively this British Treatment plan and I would recommend a perusal of this to members of the committee. I should like to add something myself to what Dr. Stevenson has said in *The Bulletin*. We have unsuccessfully endeavoured to ascertain through the R. C. M. Police liaison in the United Kingdom, as well as by direct discussion with the United Kingdom authorities, wherein their system of narcotic control differs from ours to an extent that would constitute anything that could properly be called the British Treatment plan. According to the information which has been officially given to us by the United Kingdom, they maintain as strict a control of the supply and distribution of narcotic drugs as we do.

I understand, however, that they do not have the same requirements in that country respecting reports to be made by wholesalers and druggists as we do in Canada. The furnishing of narcotic medication to addicts solely to support addiction is regarded as improper in the United Kingdom. I make that statement because it is often thought that the contrary is the fact in the United Kingdom. Ambulatory treatment is frowned upon and the authorities advise that they are quick to take appropriate action whenever a case comes to their attention that a doctor is supplying drugs to an addict. In so far as the criminal addict population is concerned, the authorities report this to consist of a very few persons and nothing like the number that we admit as existing in Canada.

The CHAIRMAN: Just what is ambulatory treatment?

Hon. Mr. MARTIN: It means the treatment of an individual other than in an institution under medical supervision. Medical authorities do not consider treatment of an addict other than in an institution with proper facilities and supervision to offer any real chance for success.

I am informed that the legal consumption of drugs in Canada on a per capita basis is, if anything, less than it is in the United Kingdom. I do not suggest that there is any significant deduction to be made from this but it is a fact to be taken into account in trying to make a comparison between the two countries. If the United Kingdom and France have a better system of control I would certainly like to have that exposed and to see if there is not something wrong with our system. If their figure of 300 is right and our figure of 3,000 is exact, then there is undoubtedly something wrong with our system in the absence of adequate explanation, but I find it difficult to accept the figures which are produced before me with respect to drug addiction in other countries. These figures were given in the United Nations. They are not figures that were given by the United Nations Secretariat, they are figures given to the United Nations by officials in charge of the enforcement problems in these various countries.

I thought it appropriate to say something along these lines because so much has been said about the merits of the British system as compared with the system employed in this country and to cast some discredit upon our methods of dealing with our drug problem. If anyone is able to explain wherein there is a difference between the British and the Canadian systems, I should be very glad to be informed. If anyone can explain to me why there should be virtually no criminal addict population in the United Kingdom in

comparison with the admitted criminal addict population in Canada, I should be very glad to have their explanation.

Senator HOWDEN: They have no institutions over there for the confinement of addicts during treatment?

Hon. Mr. MARTIN: No. We have not been able to find out any logical basis for the differences that are reported.

Suggestions for the committee: I would like to make a few suggestions to the committee in order to have a background against which the evidence which this committee will hear can be viewed. You may wish me to suggest the names of some persons who among others will be informative to you, and if it is your wish that I do so, may I suggest the following names for your consideration: You may want to call Dr. G. D. W. Cameron, Deputy Minister, National Health and Welfare; Mr. K. C. Hossick, who is in charge of the narcotic control division; Dr. C. A. Roberts, head of the Mental Health Division; Dr. G. H. Stevenson, to whom I have already made reference; Dr. Harris Isbell, Research Director of the Lexington Institution and perhaps the man who has done the most research on this whole problem; Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries in Canada; Dr. Karl Stern of the Department of Psychiatry of Ottawa University; Dr. Alastair A. MacLeod of Montreal, and Professor Stokes of the University of Toronto. I have already suggested that you might want to call Dr. Lowery, who is the head of the Lexington Institution. Undoubtedly there are many others. I offer this list not as exclusive, but as suggestive.

In addition, of course, to these persons, Commissioner L. H. Nicholson of the R.C.M. Police authorizes me to say that he will make available officers of his Force to give testimony on that portion of the problem which is their responsibility.

In addition to the persons I have mentioned, there are of course many groups and agencies who are deeply interested in the drug problem and to whom the committee will wish to give an opportunity of presenting their views. I would not want to leave the impression that you should not call anyone who would in any way throw any kind of light on this very important problem. We have in this matter no closed minds; we are anxious to bring about the best kind of policies to meet the problem in any of its aspects. I have only attempted to outline the names of persons who are more or less connected with the official side of the picture and who I think will be in a position to give authoritative information to the committee.

In conclusion, may I express the hope that the statement which I have made has been helpful. I have endeavoured in outlining broadly something of our problem to do so in as factual a way as I can. I have not consciously attempted to exaggerate or to minimize its size, importance or its seriousness. I hope I have indicated to the committee my desire to give to the problem the most earnest and sympathetic consideration that I can and to be receptive to any proposals which seem to have merit as leading towards, if not a solution, at least a better handling of the situation.

I would not wish the impression to be gained that I profess to be an expert on the subject. Necessarily I have included in my remarks the views of many who are better qualified to speak of the subject than I. These views can best be elaborated and explained by those concerned when they appear before the committee. I have merely attempted to give to this committee at the opening of its deliberations a broad general picture of the drug problem as it appears to us from our experience in dealing with it. I have endeavoured to outline some of the proposals that have been advanced for its solution. I have done this in order that the evidence that the committee will in due course hear can be related to the problem as a whole and not only to bits and pieces of it.

May I say in conclusion that as Minister of National Health and Welfare in Canada, I am glad that this investigation is under way. It is, as all will agree, of the greatest importance and it can well establish a solid foundation on which Canada will be able to follow the most realistic and advanced narcotic policies that any country which recognizes a drug problem could desire to have.

The CHAIRMAN: Honourable senators, have any of you any questions that you would like to ask the Minister, after hearing the brief?

Senator HORNER: Is the Kentucky Institution, of which you have spoken purely for the State of Kentucky, or does it take outside cases?

Hon. Mr. MARTIN: No, it is open to the whole of the United States. It is a federal institution, and the full cost of it is borne by the federal government. Such an arrangement is apparently possible in the United States, because of differences in the constitutional allocation of powers.

Senator HORNER: One other question: is it the Dominion Government that undertakes to keep a record of wholesale and retail sales of these drugs?

Hon. Mr. MARTIN: That is right.

Senator HORNER: That is purely a Dominion duty?

Hon. Mr. MARTIN: Yes.

Senator HOWDEN: That is, by legitimate routes.

Hon. Mr. MARTIN: Yes.

Senator HOWDEN: From your statement here, it would look as though this is largely a provincial affair.

Hon. Mr. MARTIN: Jurisdictionally there is no doubt that it is a provincial affair; that is, the matter of the enforced custody and the treatment. But I wish to add to that, because what I say will go out, and some may say that the federal Government is seeking to dodge responsibility. Under the National Health and Welfare Act, section 5, the Department of National Health and Welfare exists for the purpose of co-ordinating and supplementing the activities of the provinces in the health and welfare field; and, as you know, in May of 1948 we adopted a program of grants in aid to the provinces in the matter of health. It would be possible under the national health program for us to give financial help to provinces in respect of plans and projects which do not come within our constitutional authority but which we regard as deserving of financial assistance. I would not want this statement in any way to be interpreted now as a commitment to any province for any project, but we will examine any project—as I have indicated to the Attorney-General of British Columbia—that comes within the scope of our authority.

Senator HOWDEN: It just amounts to this: addicts are of two types,—those who would like to be relieved, and those who do not want to be relieved. The ones that do not want to be relieved will fight it desperately; but I would think that, from statistics which have been presented to us this morning, our problem is still in the bud, and if we can nip it in the bud it would be done much more easily than if we wait until we have a stupendous number of addicts. I gather from what you say that the matter is really within the provincial jurisdiction, which you are ready to assist from time to time. In that respect I do think that until the provinces of Canada other than the definitely lesser ones have an institution of their own, we shall have a continuation of the trouble that has existed so long. We have had no place for these people to go. That has been a great detriment to effective action. I imagine that the major provinces of Canada will have to consider the establishment of individual institutions. At any rate that is the way I feel about it.

Senator HODGES: May I ask you, Mr. Minister, in reference to your statement as to the treatment of drug addicts, whether anything is done in

connection with the treatment of these people who are in prisons for offences other than connected with trafficking in drugs?

Hon. Mr. MARTIN: Do you mind if Dr. Gendron, of the Penitentiaries Commission, deals with that? It comes within his authority, and I think what goes on in the prisons had better be dealt with directly by him.

The CHAIRMAN: Are there any questions which honourable senators would like to ask the Minister while he is here?

Senator HORNER: The Minister has spoken about Mr. Hossick. I take it he is not a medical man.

Hon. Mr. MARTIN: He was formerly in the Royal Canadian Mounted Police, in charge of a division, but he has acquired a very wide interest in this problem altogether apart from the fact that he had very considerable experience in the Mounted Police. I can assure you that his work is supplemented by the work of others in the Department of National Health and Welfare. In many respects this problem has relation to mental health, and the services of the head of our Mental Health Division, in the person of Dr. Roberts, who I think is one of the very distinguished men in Canada—

Senator BAIRD: I presume he comes from Newfoundland.

Hon. Mr. MARTIN: —is available too. As Honourable Senator Baird has said, the fact he comes from Newfoundland only serves to confirm my high estimate of his qualifications.

The CHAIRMAN: Are there any other questions? Mr. Martin, may I on behalf of the committee members extend to you our very sincere thanks for coming here this morning. I would suggest that the members of the committee remain for a few minutes, for there are one or two matters I should like to place before them off the record.

Whereupon the committee adjourned.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

EVIDENCE

OTTAWA, Tuesday, March 22, 1955.

The Special Committee on the narcotic drug traffic met this day at 10.30 a.m.

Senator REID in the Chair.

The CHAIRMAN: Gentlemen, we have a quorum. If you don't mind, I think we will start this morning's proceedings. We have this morning as a chief witness before us Mr. Nicholson, the head of the Royal Canadian Mounted Police, to place before you the brief he is going to read. Following his brief, if there are any questions any members of the Committee would like to ask him, I believe he will be very pleased to answer them.

Mr. A. H. LIEFF, Q.C.: Mr. Commissioner, before we start, it might be valuable to have on the record the length of time that you have been engaged on police work, and, perhaps, the length of time that you were in charge of criminal investigations and that sort of thing.

Commissioner NICHOLSON: Mr. Chairman, I have been engaged in police work for about thirty years. While in the field I did not have a great deal to do with drug work. Since coming to headquarters in 1946 I have had to do with it in the sense of policy direction and of the handling of the headquarters aspect of big cases. I have also made it my business to visit centres where this is an important part of our work and accompany our men on raids and on investigations.

I welcome the opportunity to appear before this Special Senate Committee and to express here some of the facts known to the R.C.M. Police concerning the illegal drug traffic. Should the Committee wish other members of the Force to supplement my evidence in any way this will be arranged.

I am sure that the Canadian Police generally will look forward to the report of this Committee and am equally sure that it will be of help to us in our enforcement work.

Drug addiction and the illegal drug traffic have received a great deal of publicity during the last few years. Unfortunately some of that publicity has favoured sensationalism rather than accuracy. As a result there exists, I think, a good deal of misunderstanding as to the extent and nature of this problem in Canada. The examination of the facts and the report planned by the Committee should—among other benefits—do a great deal toward bringing the narcotic picture into proper focus.

R.C.M.P. Responsibility: As the O. & N.D. Act is a Federal Statute responsibility for enforcement falls upon the R.C.M.P. The Force has had this task throughout Canada since 1920 when its jurisdiction was extended to cover all of the country. Prior to that time the R.C.M.P. did a certain amount of work in this field in areas where its members were located.

In application we use full time drug squads at those centers where that attention is indicated. These squads are reinforced as necessary by men from general duty or other specialist details. I would add that such reinforcement is quite a usual thing. We have to call upon other men frequently and for long periods in order to support the drug squads.

Administration of the Act is a responsibility of the Division of Narcotic Control, Department of National Health and Welfare. At times and upon request the Force assists that division in the carrying out of certain administrative tasks.

Co-operation with the Department of National Health and Welfare, other Departments and Agencies: The liaison and co-operation between the Division of Narcotic Control, Department of National Health and Welfare, and the R.C.M.P. is, in my opinion, all that could be desired. Very close and satisfactory three way liaison is also maintained between the Department of National Health, the Department of Justice and this Force in all legal matters, including arrangements for prosecutions and the study of existing or draft legislation touching upon drug control.

Mr. Hossick, Chief of the Division of Narcotic Control, is also the Canadian Representative on United Nations Narcotic Commission. He has an exact knowledge of the international traffic and the workings of international controls. I understand that Mr. Hossick will appear before this Committee and I will not therefore attempt to deal with the international aspects of the drug traffic.

I do wish however to assure the Committee that the liaison between all interested departments in all matters touching on this traffic is very close and very satisfactory—and I should add that the system of controls set up by the Division of Narcotic Control for the distribution of legitimate drug supplies within Canada is such that there is little or no leakage from the legal into the illegal drug market.

Cooperation with other Forces: At this point I might mention that most of the major municipal forces in Canada maintain a special narcotic investigation squad which works closely with the narcotic squads maintained by the R.C.M.P. This Force concentrates particularly on the investigation of traffickers. On the whole the cooperation between this Force and Municipal Forces is very satisfactory.

I would be discourteous if I did not mention as well the close link we have with the U.S. Bureau of Narcotics and the great help we get from that agency. We get the very best type of help from that Bureau.

I might also interject that we have a membership in the International Criminal Police Commission, a body that maintains a Bureau in Paris. As the Canadian member we have access to that Bureau and its records, and are able to tap it at any time for purposes pertaining to drug traffic and drug control—that is, the enforcement aspect. We also maintain—speaking of liaison—an officer in London and in Washington, and we use those officers as may be necessary for liaison purposes relating to drug traffic.

Outline of Drug Traffic: As the Minister of National Health and Welfare said in his statement before this Committee the drug traffic is operated by a variety of persons and offers large profits. It may be of some value if I attempt to summarize that traffic and deal briefly with its various levels. When I speak of addicts here, as well as throughout this statement, I am referring to the Criminal Addict—that is the addict who supports his addiction by crime or gets his narcotics from illegal sources—and these conditions usually go together.

May I at this point emphasize that we are dealing with an underworld traffic and for that reason the practices within the traffic, the flow of its supplies, its prices and profits may not be as clearly defined or charted as in a normal business. Transactions—carried out in deepest secrecy, of course—are arranged through meetings between constantly changing contacts and connections, all of whom are criminals. The very nature of the traffic gives rise to peculiar and involved situations.

As an example it is quite possible—and in fact frequently happens—that narcotics will be moving in both direction across the Canadian—U.S. border, or between two points within Canada, at about the same time. A buyer in Canada, may, through his contacts, locate a source of supply in the U.S., while a U.S. buyer is negotiating with a trafficker in Canada who has by some means secured a supply of drugs—possibly from a U.S. source.

It is, therefore, misleading to think of a regular flow in a regular way, involving a regular practice, all the time. There are trends, but a good deal of irregularity.

For similar reasons prices, which depend on supply and demand at the exact point of delivery and on other pressures that may be present, may vary widely across Canada and may even vary considerably within the same city.

I mention this in order that the members of this Committee will understand why I may not be as precise as they might wish in summarizing the traffic. I will deal with general trends, but these trends are subject to exceptions that may at times seem almost contradictions.

For many years most of the illegal drug supply reached Canada through our seaports. This is no longer true. The general flow of narcotics today is from the United States into Eastern Canada.

In turn in past years, opium, morphine and heroin were the common drugs of addiction. Today the illicit drug traffic is almost entirely in heroin.

In other countries—the United States, Mexico and England among them—the drug Cannabis Sativa or Marihuana or Hashish—presents a problem of considerable proportion to enforcement authorities. No problem exists in Canada at present as regards that particular drug. A few isolated seizures have been made but these have been from visitors to this country or in one or two instances from Canadians who have developed the addiction while living in other countries.

I have said that the general flow of narcotic drugs at present is from the United States into Canada. At that level—that is the level of the Canadian importer—fairly large quantities of drugs are handled—quantities ranging from a few ounces to a kilogram or more. The drug—and I am speaking of the common drug of addiction, heroin—if it could be imported legally has a value of about \$12.00 an ounce. In the illicit traffic the price—that is, the price the Canadian importer pays if he goes seeking and buying it in the States—to the importer is in the neighbourhood of \$300.00.

In order that the members of this Committee may appreciate the difficult or I might say the impossible task of sealing the thousands of miles of friendly border between this country and the United States against such importations I am now submitting a one kilo can.

Senator BAIRD: Two pounds two ounces?

Commissioner NICHOLSON: Yes, about two pounds two ounces.

This kilogram tin, if filled with heroin, would contain a little more than 35 ounces and would cost the importer about \$11,000. The contents would be sold by him usually in smaller quantities at prices that would bring him from \$19,250 to \$28,000. That profit would be increased if the importer could manage to adulterate the drug before sale.

Senator HOWDEN: What would they adulterate it with?

Commissioner NICHOLSON: Milk of sugar. It is of interest to note at this time that this kilo tin would contain sufficient heroin for approximately 60,000 injections.

The importer usually disposes of his stock in ounces to local traffickers. The bottle that I am now producing would contain an ounce of heroin. The price of it to the local trafficker would be from \$550 to \$800.

The next step in the traffic is subject to many and constant variations. The local trafficker may dispose of his stock in an ounce, a half ounce or quarter ounce lots to smaller traffickers or he may dispose of it directly to the criminal addicts through agents working for him.

For sale to the addicts the drug is usually put up in capsules such as the one I am now producing. The price of these capsules containing $\frac{1}{4}$ grains to the addict ranges from \$3.00 to \$5.00. The supplier, therefore, receives from \$5,200 to \$8,700 an ounce.

Senator HODGES: Excuse me, but may I ask if one capsule is a dose?

Commissioner NICHOLSON: One capsule is a quarter grain, and is the normal quarter grain dose. The capsule used by the peddler carries a quarter grain, but it would not be correct to say that it is exactly—

Senator HODGES: But it is a dose?

Commissioner NICHOLSON: Yes.

The CHAIRMAN: And how many does the addict use in a day?

Commissioner NICHOLSON: It varies so much that it is hard to be precise. He may use six, seven or eight capsules, or he may get by with fewer. I think the hardened addict would use perhaps five or six capsules a day if he could get them, but that would be a heavy dose.

Senator HOWDEN: That would be spread over the whole day?

Commissioner NICHOLSON: Yes; but mark you, I do not suggest that it is an average daily dose.

Senator QUINN: That is five of the capsules you have shown here.

Commissioner NICHOLSON: Yes.

The CHAIRMAN: That would mean a cost of from \$15 to \$25 a day?

Commissioner NICHOLSON: Yes. As I say, it is hard to hit an average, because supply is a feature, as is condition and finances.

It will be noted that at addict level the contents of the kilo can, which costs the importer about \$11,000 has risen to somewhere between \$179,000 and \$290,000. There are various ways of getting these totals, and if you use another scale you will get a different total. We have taken it on the conservative side, and have not included any factor for adulteration. It would be usual to find some adulteration somewhere down the line of distribution.

I understand that the Committee is to be shown a film that deals with the devious and surreptitious methods followed by traffickers and addicts alike in their efforts to evade the Police. Therefore, no very useful purpose will be served by a detailed account by me of these methods of distribution. Members of the Committee may, however, be interested in examining these exhibits which I now produce which serve as good examples of the evasive efforts of traffickers.

I have brought along two or three articles to indicate methods that addicts use for concealing drugs. This article I am showing you is a vest with pockets in it and it is worn under the normal clothing. These slits that you see here are just about right for the normal size tin.

Senator BAIRD: That is the inside of it that you are showing I presume.

Commissioner NICHOLSON: Yes.

This is a religious book with the inside cut out and able to contain quite a stock. This is a Chinese magazine, also cut out. This is a shoe with the heel removed and the inside of the heel cut out and then the heel renailed and polished over. The cavity in there is large enough to carry quite a good supply.

Senator HODGES: That is, of heroin?

Commissioner NICHOLSON: Yes, of heroin.

Senator HOWDEN: It would be too bad if the wearer walked through water, wouldn't it?

Commissioner NICHOLSON: I should think he would be very careful about it if he had it loaded.

Now the big importer or dealer is seldom an addict himself. It is well to stress that. This is a point on which there is misunderstanding. The big dealer does not try to encourage addiction. He avoids contact with his victims realizing that in such contact lies the greatest danger of detection.

The street corner trafficker or pusher as he is called is on the other hand frequently also an addict. Addicts may also be found among the smaller type

distributors. As pointed out by the Minister of National Health and Welfare in his statement at last Tuesday's meeting of this committee, it is not always possible to make a simple and clear division between the drug dealers and the addicts.

While the addict as such may be deserving of sympathy and because his motivation is a drive of addiction rather than the profit, he cannot be regarded as being in the same vicious class as those criminals who traffic solely for money. The addict does however forfeit much of this sympathy when he becomes involved in distribution.

The committee will appreciate the difficulties facing enforcement authorities in their attempts to wipe out a traffic which offers the high profits that I have mentioned in return for the handling of such very small quantities of merchandise.

Volume and distribution of traffic—Statistics—Tables: For the information of the committee I have had prepared two tables giving figures dealing with enforcement, and which figures have some value in indicating the location of addicts and the proportions of the traffic in Canada.

Table No. 1 (*See Appendix D*) shows the number of convictions year by year since 1921 under the Opium and Narcotic Drug Act and secured by the R.C.M.P.

Table No. 2 (*See Appendix E*) is an analysis of the location and records of 2,009 known criminal addicts.

You will perhaps at once perceive a little difference there, in that we say there are 2,009 criminal addicts while the Minister of National Health and Welfare in his testimony the other day gave the figure as 2,364. Perhaps I might explain the difference.

Our examination is based on criminal files, that is files arising from a conviction. The convictions may be either for an offence under the Opium and Narcotic Drug Act or for some other criminal offence dealt with by indictment. In other words, all of these 2,009 people have been fingerprinted and their fingerprint record is held in our National Bureau. Our total of 2,009 therefore is based on that factor, whereas the departmental examination and total was based on just known criminal addiction. I would offer the suggestion that there are probably a good many addicts who may have some sort of a police record but not including an indictable offence.

Senator HODGES: And may there not be many others who have not been apprehended for anything?

Commissioner NICHOLSON: Yes; there would be a number, perhaps, of that sort.

Opium and Narcotic Drug Act—Enforcement Features: On June 10, 1954, several amendments were made to the Opium and Narcotic Drug Act, the chief of which, from an enforcement point of view, was the new provision in Section 4 which was aimed at the more important type of trafficker or distributor. Since that time convictions have been secured against 24 traffickers with sentences ranging from 2 to 14 years' imprisonment. In addition 15 other traffickers are presently before the courts.

In my opinion the arrest and punishment of traffickers will not alone put an end to the illicit narcotic drug problem in this country.

Mr. Chairman, I might stop and say I take it you wanted a general statement, and I have placed here an opinion; I take it that is what you wished.

The CHAIRMAN: Right.

Commissioner NICHOLSON: It is true that such arrests cause a great deal of confusion among traffickers and serve to exercise some measure of control and to interrupt the flow of drugs for a time. However, profits are so attractive that the gaps caused by arrests are quickly filled by other criminals and the traffic continues.

I suggest that this vicious distribution will be brought to an end only by a removal of the demand and any other remedy is—at best—a partial and incomplete one. I will enlarge upon this point later in this statement.

To support my contention that more strict enforcement will not provide a complete answer to the problem let me point out that since 1949 the Royal Canadian Mounted Police has apprehended and convicted 36 major traffickers. In these cases penalties ranged from 2 to 28 years' imprisonment.

Senator BURCHILL: What do you classify as a "major" trafficker?

Commissioner NICHOLSON: I think I could illustrate that by passing around a number of files which I have here from the 36, which will show their records, their pictures, and something of their operations.

Senator BURCHILL: They are in business in a big way.

Commissioner NICHOLSON: Indeed yes.

The CHAIRMAN: Would they be the top men?

Commissioner NICHOLSON: These would be the top Canadian operators.

Senator HODGES: The heads of the rings?

Commissioner NICHOLSON: Indeed. There are just nine files there, and I might comment on them perhaps. It is only fair to say that a vast amount of effort goes into these cases and I should like to describe something of what is involved.

I have deleted the name of each of these traffickers, but the picture is there, the record is there, and other identifiable particulars. I would be glad if the photographs and, indeed, the identifiable particulars would not be published.

Mr. CHAIRMAN: May I point out, Mr. Commissioner, that if there is any evidence given this morning which you do not want to be on the record, we will delete it.

Commissioner NICHOLSON: Very good. The only thing I would not want published is the identifiable particulars of these traffickers or their photographs.

The CHAIRMAN: May I point out to the Press to use discretion on these secret files in taking secret information and publicizing it.

Commissioner NICHOLSON: All traffickers have had a great deal of experience in evading arrest and all are extremely crafty and cautious in their handling of narcotic drug deals. The caution, of course, increases in proportion to the amount of drugs being handled.

When attempting to bring about the arrest of an important trafficker weeks and often months of observation and surveillance work are necessary on the part of the Police. At times an informant is made use of but a key step is often the introduction of a member of the Force to the peddlers in an attempt to put that member in a position from which he may gradually work up from street level transactions to the important supplier level. While this development is occurring information regarding the methods employed by the trafficker is being secured, if the Police are fortunate, through the informant, that is, if they are able to work in that way. At any stage of the investigation the trafficker or members of his organization may for some reason become alarmed and suspicious of the informant or of the undercover man and may bring the entire extensive investigation to a premature end.

When the undercover member or agent has been able to secure the confidence of the top members of the organization attempts are made to purchase narcotics in quantities sufficiently large to involve the participation of the supplier and of his important aides. When we get to that stage in the operation we want to be sure that we do not cut off our case with some relatively unimportant agent or lower level operator. Our particular target is to get to the man on top, so we have to work in that direction, and one thing is to make the purchase or purchases large enough to bring the big fellow in. He won't show

himself for little transactions, but he may show himself if the transaction is big enough and there is enough money in it. If successful in this effort, as we say, we "blow up the case", members of the organization are charged and the evidence gained during months of intensive enquiry is presented to the courts.

For the protection of our undercover member and in order to obtain the necessary corroborative evidence constant observation must be maintained of every move made. The difficulties encountered in attempting to maintain surveillance of criminal activities being carried on underground are obvious. That is a big operation. Each move of our cover man has to be watched, if it is at all possible, so that there is corroborative evidence of the various developments as the case unfolds.

Invariably the investigation is complicated by the practice of traffickers attempting to insert into their organizations at various levels persons not known to the Police and also by their habit of false meeting places and false delivery arrangements which are set up in order to test the genuineness of alleged purchasers.

That simply amounts to this: when the transaction seems to be just about ready, a place of meeting will be arranged in a very devious fashion, at which place our man expects to take delivery of the drug and to hand over the money, and that area has to be covered as best we can, so that if a transaction does take place there will be evidence, not alone of the under-cover man, but of others. Frequently that arrangement is a fake set up by the trafficker, by the agent or the operator, just to test us to see whether, as he drives up or as he comes up, he may be pounced upon and arrested, or something may disclose itself which will indicate to him that he had better be careful. These tests are quite normal in a case of that sort.

The CHAIRMAN: They think of everything, eh?

Commissioner NICHOLSON: Indeed they do.

An operation such as this involves the use of radio-equipped cars, portable radios, special equipment and a large squad of men over long periods of time and as I have said months of investigation may, and frequently are brought to an abrupt end by the caution or suspicion of the traffickers. For the members working under cover it is a nerve-racking and often a dangerous assignment.

I mention these things to show that we have made a serious effort to kill narcotic drug traffic by strict enforcement but despite this effort we have not been successful. So long as the demand for illicit narcotic drugs exists there will be criminals to supply it.

Study of Case Files: I have recently had an examination carried out of the files and records of 2,009 criminal addicts. Some of the facts disclosed by that study may be of value in removing misapprehensions that have been built up by the publication of wrong or misleading information.

From some of the more sensational types of publicity that have been given the narcotic traffic the impression might be gained that innocent persons are lured, coaxed or forced into addiction and that a life of crime starts with addiction.

Of the 2,009 cases studied 341 were convicted first under the O. & N. D. Act; 1,220 were convicted first for some other offence and later under the O. & N. D. Act; 448 are known addicts with criminal records but their records do not include Drug Act convictions.

That means that out of 2,009 cases involving criminal addicts, 1,668 involved people who were very probably criminals before they were addicts. That is about what it amounts to.

A table attached to this statement gives a detailed breakdown of the cases studied.

We have no evidence indicating that innocent persons are dragged or forced into drug addiction. All of our evidence establishes rather that these individuals enter into a life of crime and through association with criminals and possibly because of some inherent weakness or mental characteristic become addicted to drugs.

There has been considerable publicity given an alleged high school or teenage narcotic problem in Canada. Of the 2,009 records studied only 25 males and 29 females were under the age of 20 at the time that they were first convicted under the Drug Act. These figures plus the constant flow of information reaching my Headquarters from our investigators in the field, and from the investigators of other police forces establish that very definitely, to my mind, there is no so-called teenage or high school narcotic problem in Canada.

It is sometimes held that the average drug addict is anxious to be cured of his addiction. May I point out that while serving sentences in jail, addicts are not given drugs and that at the end of their term of imprisonment they will have been without narcotic drugs for the length of that imprisonment. It follows then that at the time the prisoner is released he has been cured of his physical demand for drugs. Nevertheless there is not one case in the 2,009 studied in which the individual, following his first conviction and sentence, has not returned to jail either for a narcotic offence or for a crime usually associated with the attempt of addicts to secure funds with which to continue their addiction.

In all these cases the criminals are what are known as "one-time repeaters". They have returned to jail at least once.

Senator HODGES: Is that irrespective of the length of the sentence?

Commissioner NICHOLSON: Perhaps I should qualify that. They might be given drugs under medical attention.

Senator HOWDEN: But not very much?

Commissioner NICHOLSON: No, it would be a matter of treatment of some sort.

Senator HOWDEN: Well, then, when they are released from jail they could be free of the drug habit if they wanted to be?

Commissioner NICHOLSON: Yes, they would be physically clear of the drug habit.

Senator HOWDEN: Are many drug addicts treated in that way?

Commissioner NICHOLSON: You mean of their own volition?

Senator HOWDEN: Men and women who are taken into custody and treated in the way you mentioned. I think you said they are given a little morphine when it has been absolutely necessary to break them off a drug for the time being.

Commissioner NICHOLSON: That raises the question of the manner in which medical people may administer these drugs. I would say that the treatment would be restricted to what the medical men consider necessary to cure some condition that the addict is suffering from.

Senator HOWDEN: That brings a point to my mind. Are all these interned addicts presented to some medical authority for treatment.

Commissioner NICHOLSON: I cannot answer that, I am afraid, sir.

Senator HODGES: I am interested in what you say here because allegations have been made in the press from time to time that drugs are smuggled into some of our penal institutions and that drug addicts in these institutions have, shall I say, encouraged others to partake of the drugs. Have you any substantiation of that allegation?

Commissioner NICHOLSON: Yes, there have been cases where drugs have been smuggled into jails and places of internment of some sort or another. I do not think it is extensive.

Senator HOWDEN: It would be most unsatisfactory from the standpoint of the addict. It would be hit and miss. Unless the addict has a steady stream he is not a very happy individual.

Commissioner NICHOLSON: There have been cases but they are isolated.

Senator HODGES: Is there any truth to the allegation that drug addicts in jail and penitentiaries influence others to become drug addicts? That is another allegation that is important. Have you any knowledge about that?

Commissioner NICHOLSON: I would have some doubt as to that because a drug addict in jail, if he manages to get a supply, will want to keep it himself. If he is getting it in jail he is probably getting it from outside, but I do not think there would be any general spread of the habit within a jail. It would be very unusual and isolated.

Senator LEGER: And the other prisoners would not have money to buy the drugs from him.

The CHAIRMAN: It is startling to hear the statement that no matter how long a drug addict has been incarcerated he will endeavour to take drugs as soon as he is out of jail or prison.

Commissioner NICHOLSON: My next statement deals with that.

Whatever the reasons may be it is clear that addicts of the criminal type seldom if ever under our present method manage to shake themselves clear of the vicious habit and take a respectable place in society.

Senator TURGEON: Do you know the average length of time these addicts spend in jail?

Commissioner NICHOLSON: The sentences vary so much that I do not think I could give you an average.

The CHAIRMAN: May I point out to the members of the committee that we shall get closer to this picture when we have before us penitentiary wardens and the superintendent in charge of penitentiaries. At that time we will get closer to what happens inside these institutions.

Commissioner NICHOLSON: I have here a number of case files of addicts, which I propose to leave with you. They show the length of sentences in these particular cases. I would ask again that the identifying particulars and the photographs might not be subject to publication.

It will be noted that many items appear on the records of these criminal addicts—some for possession of drugs and some for minor types of crime such as are commonly resorted to by addicts in order to secure funds to satisfy their addiction. This pattern of a short term of freedom, the commission of an offence, a term of imprisonment and another short period of freedom is repeated over and over again in the records of addicts and tends to support, I think, what I have said regarding the failure of enforcement methods alone to have any real corrective effect on the drug addict.

The case files placed before you are those of typical addicts. Psychiatrists and sociologists may explain the fundamental reasons which led to the unhappy condition these people are in. From the standpoint of the police, who see them from day to day, they are a dreary lot of parasites, supporting themselves and the habit to which they are enslaved by crime and prostitution. Regular employment is to all intents and purposes unknown to them and few make any effort to get any sort of a job. They are in truth the dregs of society.

The CHAIRMAN: May I ask, Mr. Commissioner, if these drug addicts do any work, when they come out, or does the drug addiction take away the desire for employment?

Commissioner NICHOLSON: Very seldom do we find them with any regular work. That would be most unusual. If they do work, the work is usually of some intermittent character that is just embarked upon just for a short time.

Senator HODGES: I suppose that is why they turn to crime, in order to raise money for drugs?

Commissioner NICHOLSON: Yes, indeed, because they are not of the type that could hold any legitimate job which would lead to a position big enough to support their addiction.

Treatment of the Problem: I have reviewed in some detail the factors affecting this problem as they are appreciated by the Royal Canadian Mounted Police.

Now, in concluding my remarks, I should like to offer a few comments as to the method or methods which might be employed to reduce and ultimately eliminate narcotic drug addiction.

Broadly speaking three courses have been advocated by students of this problem in recent years. The first is more rigid enforcement and control. The second is the provision of narcotic drugs by legal means and at something like cost price to addicts. The third is strict enforcement plus the compulsory isolation and treatment of addicts.

I have already said that the first course seems to hold little promise of complete success. The police in Canada have made persistent and aggressive efforts to kill the traffic by identifying and prosecuting the trafficker, including the street peddler and the addict peddler. These efforts have been carried out over a number of years. We have not been successful in putting an end to the traffic and I don't think we ever will be by enforcement methods alone.

Tremendous profits are available to traffickers and as I have tried to demonstrate by producing here the typical quantities—the small amounts of drugs required for even an extensive illegal trade makes the detection of smugglers and handlers exceedingly difficult. Strict enforcement will provide a measure of control and will visit richly deserved punishment on traffickers but it will not alone eliminate illegal addiction.

Senator HOWDEN: You would say that until the demand is destroyed we will have the traffic?

Commissioner NICHOLSON: I am afraid so.

The second course—the provision of drugs in a legal way to addicts—would, I think, not only be unsuccessful but would be a backward step. In the final analysis I would fear that the rate of addiction would be increased rather than decreased.

Senator HODGES: That means that you are not in favour of the suggested clinics?

Commissioner NICHOLSON: Not in favour.

At first glance the legal provision of drugs to addicts would appear to be an extremely simple way of doing away with the demands for illicit drugs and, therefore, ending the illicit traffic. There are, however, I suggest a number of practical considerations that have been overlooked by the proponents of this system which, by the way, has been experimented with in the United States with uniformly unsatisfactory results. The advocates of this system hold that the addict should receive free or at least at cost price the narcotic drugs that he requires but do they mean that the addict would be given the amount that *he thinks he requires* or would the amount be limited by medical opinion?

I doubt that even the strongest advocate of this system would suggest that the amount given should depend on the demands of the addict. We know that drug addiction is a progressive ailment with the dosage increasing as tolerance increases. The result, therefore, of supplying *the demands of addicts* would be that these "free filling stations" would tend to increase the dosage of the addicts instead of aiming at cure.

Would the suggested clinics carry an assortment of drugs—heroin, morphine, cocaine, opium? Would an addict be able to drop in for a week's supply of marihuana cigarettes—and if not, how is it proposed to differentiate between addicts and addictions?

If the quantity and nature of drugs supplied is to be governed by the opinion of the authorities operating the so-called "clinic" the addicts would accept very gladly such drugs as they were able to get—and would secure the balance of their requirements elsewhere—and the illicit traffic would still flourish.

Particularly troublesome problems would arise if, under the proposed system, drugs are handed out for self-administration. Should a limited quantity be given the addict for self-administration it may be assumed that some part of what is so given will find its way into the illicit market. It may also be assumed attempts will be made by non-addict criminals to pose as addicts in order to secure drugs which can be sold in the illicit market.

The CHAIRMAN: Right there, can you tell whether a man is a drug addict or not by marks on his body? Suppose he came forward and said he was, and actually was not, but was looking for drugs?

Commissioner NICHOLSON: Well, I do not think it is possible to prove or disprove just by marks on his arm, but from the clinic standpoint, if a man came in and claimed to be an addict and had marks on one sort or another on his arm, it seems to me there would always be some difficulty in whether he should be denied the right, or whether it should be given to him.

Senator QUINN: Can it be ascertained by blood tests?

Commissioner NICHOLSON: I think that would be a matter for medical attention. I do not think so. There are other methods of telling an addict. I will come to that later, if you wish.

From the enforcement point of view another important consideration is the fact that registered addicts who were receiving limited quantities of drugs from a Government clinic and who were going to the illicit market for the balance of their requirements could at any time claim that drugs found in their possession were drugs legally in their possession. The resultant difficulties the police would face are obvious.

If the addict is to receive dosage at the so-called "clinic" and as his addiction would require several injections daily (up to 7, 8 or 9 if his demands were to be met) it is extremely difficult to imagine how it is hoped that he could be rehabilitated and carry out a normal occupation.

Unless the system blanketed the entire country the setting up of clinics from which addicts could secure free supplies of narcotics would, from the enforcement point of view, have one curious effect. The problem of the narcotic traffic would be very much narrowed and concentrated by the movement of addicts from across Canada to the Province or areas in which the clinics have been set up.

Then the setting up of Government drug clinics would give drug addiction a cloak of respectability or at least of tolerance which would, I fear, tend to increase rather than decrease the number of victims.

For these and other reasons I feel the supplying of free or cost price drugs to addicts would be a backward rather than a forward step.

The last of the three methods that I have mentioned as being advocated by persons interested in this problem, is, to my mind, the only one offering a real hope of success. I have described criminal addict types and the manner in which these people customarily finance their habit. So long as these people are left at large while subjected to addiction they provide the market for traffickers and by association encourage others suffering from similar personality, character weaknesses or instability, to become drug users. They also, as a corollary, impose a load upon society through their illegal activities and complete lack of productivity. I therefore feel—and I think this view is held by many if not most other police officials—that the only hope for the possible rehabilitation of these addicts and for the eradication of the drug traffic is that they be compulsorily isolated or quarantined.

Senator HODGES: May I ask a question? You say that confinement of these addicts in prison for long terms does not cure them or change their habits. What do you suggest as a period of compulsory confinement or quarantine?

Commissioner NICHOLSON: I will come to that point later in my statement.

Release should be made only when, in the opinion of those qualified to judge, there is a real hope of rehabilitation. They should, furthermore, only be released under carefully defined conditions and subject to continuing care and supervision so that the possibility of resumption of the drug habit will be held to an absolute minimum. One essential control to my mind would be suitable employment in an area far removed from that in which the individual lived whilst addicted.

I do not think that it would be proper for me to attempt to outline in detail how such a plan should be worked, and I realize that many problems would have to be faced and solved. I would, however, suggest that the objective should be to take addicts off the street completely and to provide machinery so that this action need not necessarily be connected with nor follow a conviction for a drug offence. Addicts are easily identified and the effectiveness of the plan would depend very largely upon making its coverage complete.

There is no problem of identifying the addict when they have been taking drugs and their drugs have been taken away from them; the withdrawal symptoms are very noticeable, and a medical man can quickly diagnose the condition.

Mr. LIEFF: Would you add to that, that a warden of a jail or penitentiary would notice the same condition very quickly?

Commissioner NICHOLSON: Yes; any people in touch with addicts would recognize the withdrawal symptoms very readily.

Such a plan would obviously entail heavy expenditures but I would point out that alternatively the present cost of enforcement, detention and of the offences committed by criminal addicts must add up to a substantial amount.

Perhaps I might just be allowed to stress one further point. While the effectiveness of the scheme proposed would depend upon what are seemingly harsh measures, an important feature would be the attention given to the rehabilitation of as many of these unfortunate people as possible. To this end full use should be made of modern sociological, psychiatric and medical methods. It might be borne in mind too that the circumstances under which the average addict lives while at large are sordid and unhappy in the extreme. Thus he would, during the forced detention that I have recommended, enjoy conditions, and surroundings far, far in advance of those within which he has been accustomed to exist. With good accommodation and modern treatment I would think that some of these unfortunates might be re-made into useful members of society—as matters stand at present their condition seems hopeless.

The CHAIRMAN: Do any honourable senators have any questions they would like to ask the Commissioner while he is here?

Senator GOLDING: May I ask in what centre of Canada does the Commissioner now get the most traffic in narcotic drugs.

Commissioner NICHOLSON: Vancouver.

Senator HOWDEN: I have been a medical man for some years and I have had some contact with dope fiends. My thought has always been that until we could isolate, incarcerate and control the users of dope we would get nowhere. I think it is very well to have them put to work like men in an ordinary jail, but they must, I think, feel that in respect to food and housing that they are being given the normal comforts. However, as I say I believe we must control the user, the addict, before we attempt to control the trafficker, otherwise we will get nowhere.

Commissioner NICHOLSON: Right.

Senator BURCHILL: Following the question asked by Senator Golding, you said Vancouver was the worst spot; however, in your paper I thought you said the biggest traffic was in Eastern Canada. Is the route from Eastern to Western Canada?

Commissioner NICHOLSON: Yes, the bulk of the market is in Vancouver; but if one can identify its normal route, the route now being used to the greatest extent is from Eastern United States into Eastern Canada, and thence across the country to whatever centre offers a market.

Senator LEGER: Do you mean by Eastern Canada, the Maritimes, Quebec or Ontario?

Commissioner NICHOLSON: I should like to avoid being precise on that point, because it gets down to matters which are perhaps a little delicate.

Senator HOWDEN: There appeared in a recent issue of the *Reader's Digest* an article which stated that Communist China is financing its war effort by the sale of opium; that at the end of the last war they were producing only 1,200 tons of the product, and now produce 6,000 tons, which is exported to the west coast of North America. I don't recall the author of the article, but it was most pungent in its comment.

Commissioner NICHOLSON: I think it was also carried in the latest issue of *Time*, and is a statement made by Mr. Anslinger who is head of the United States Narcotic Bureau.

Mr. LIEFF: Would you care to tell the committee, Commissioner Nicholson, why addicts tend to congregate in a definite community? Are there any specific reasons that you could enlarge on?

Commissioner NICHOLSON: I will do so as far as I can. There are one or two factors which might be considered with respect to Vancouver, which seems now to be in the forefront—however, other cities have at times been in that position. I think the possibilities of supply have something to do with it, and also the climate.

Senator HODGES: In what way would the climate have anything to do with it?

Commissioner NICHOLSON: The addicts want to keep the normal living expenses as low as possible, so that all the money they have can be spent on drugs. If they live in Montreal or Ottawa they have to have some sort of heavy clothing, whereas they can get by with lighter clothing in Vancouver.

Senator HODGES: I understand; I thought perhaps the climate created some addiction to drugs.

Commissioner NICHOLSON: I think it is a matter of ebb and flow, and it is hard to be precise about it. Further, I think like attracts like; that a group of people of that type will add to their number.

Mr. LIEFF: They have a society of their own, which suits them.

Commissioner NICHOLSON: Yes, they have their own little group, and their larger group too.

Mr. LIEFF: And their own standards.

Commissioner NICHOLSON: Yes. They have some sort of hangout or place where they can live at a minimum of cost. Further, they have to support their habit by crime, and they favour the place where they think they have the better chance of stealing; or, in the case of women, if they tend toward prostitution, they go to the centres where they can capitalize on it.

The CHAIRMAN: Commissioner Nicholson, have you heard anything to the effect that there is one large store in Vancouver that claims to lose on an average of \$200 to \$300 a day due to pilfering by addicts?

Commissioner NICHOLSON: I have heard a number of reports of that sort, Senator. I would not be able to confirm the exact amount, but undoubtedly it is the type of crime that addicts commit a great deal. The type of crime they are attracted to is not usually violent, but rather that of shoplifting and thievery.

The CHAIRMAN: The thought occurred to me that if it is correct that \$200 and \$300 thieveries are going on from one store that those who are taking those goods must be disposing of them through fences. It stands to reason that when goods are stolen in this way they are stolen primarily for sale in order that the drug addict may supply himself with money. A theft of \$300 seems to me to be quite a good-sized theft of goods and I was wondering if you could say something about the fences who buy these goods from the addicts. Has that channel been looked into at all?

Commissioner NICHOLSON: I do not think I can say anything on that. Fences operate within the cities and the local police are the ones who would be paying attention to that.

Senator HODGES: In one part of your brief, Commissioner, you say in so many words "once an addict always an addict" and in the last paragraph you seem to think quite a number could be rehabilitated if given the opportunity. Those two statements appear to me to be contradictory. Are you referring to criminal addicts in your last paragraph or to the ordinary addict?

Commissioner NICHOLSON: No, senator, I am referring to the same type of addict throughout. I think that under present conditions there is very little hope for their rehabilitation—under present conditions.

Senator HOWDEN: In other words in order to make any kind of a job of rehabilitation we would have to have institutions in which to place these people, places that we have not got in Canada today.

Commissioner NICHOLSON: Yes. I think a percentage of them could be saved. I do not know how high the percentage might be but I think that if we did have such a place, or a number of places where they might be treated there could be some salvage. I think however that would also require something more than just custody, there would have to be very careful treatment, and, also, there would have to be a lot of after care. A lot of attention would have to be given to this question of rehabilitation.

Senator HODGES: Do you think any of that rehabilitation work could be carried out in conjunction with the penal institutions?

Commissioner NICHOLSON: That would be a matter of opinion. There are a lot of pros and cons involved in that question. By and large I think the treatment institution should be apart from jails and penitentiaries.

Senator HODGES: I was thinking of the trafficker that you mentioned as having been sentenced to 28 years. Do you think that anybody should be kept in jail all that time without some attempt made to rehabilitate him?

Commissioner NICHOLSON: That man is a trafficker, not an addict. He does not even use drugs.

Senator HODGES: None of those you mentioned are addicts?

Commissioner NICHOLSON: No, not the big wholesaler. I think they are criminals and that is all there is to it, and they should be jailed as criminals.

Senator TURGEON: If any institution for the rehabilitation of addicts was to be built would it be advantageous to have it built away from a crime centre, say, such as Vancouver? I mean, would it be better to locate that institution a long distance from a crime centre?

Commissioner NICHOLSON: There are a good many factors which would have to be weighed before a decision could be made on that point, and there will be people perhaps better qualified than I am to deal with the medical aspects of the question, witnesses who could give a better opinion on the aspect of location of such an institution. I do not think I would like to offer an opinion as to where these places should be located. I would like to stop by saying that these people should be located, taken off the street and locked up.

Senator HODGES: I would like to know if there is any truth in the allegation that frequently on the release of a drug addict, drug peddlers are waiting at the jail door to greet them when they are released. That is to say pushers and traffickers are waiting to get them back as customers. Would the removal of an institution from a big city for instance do away with that aspect?

Commissioner NICHOLSON: I think there would have to be a little more than that. I think that care after release would have to be strictly related to the treatment and to the diagnosis. It seems to me that even given the best treatment it would be folly to release the ex-addict, the cured addict, and let him go back to the same old places and mix with the same old people. I think it would only be a matter of time until he was right back in the same slot again.

Personally I would stress the after care. That would be most important. I think furthermore that we should not be discouraged if the percentage of people salvaged is a pretty small one.

The CHAIRMAN: We will no doubt have some testimony on that when we meet the wardens of the penitentiaries. It is interesting to note what one warden told me, that when young men are released from the penitentiary their own parents or relatives are not there to meet him, but it was always some pal who met him when he was released and who would take him right back again to his old haunts.

Are there any further questions?

Mr. LIEFF: In Table 2 which you filed with the committee this morning, you gave as 54 the number of juvenile addicts under twenty. We were given a figure the other day by the Minister of National Health and Welfare to the effect that of the number given all of them were already known to the police and none of them were at school. Would that apply to your 54 as well?

Commissioner NICHOLSON: There is a seeming contradiction there which I should have explained as I went along. I refer to it about the middle of my statement. I think the testimony you previously had was as to the number under twenty, whereas our figure in Table 2 is the number under twenty when first convicted.

Mr. LIEFF: But all of those were known to the police and perhaps had juvenile records before they became addicted?

Commissioner NICHOLSON: I could not be certain of that because our records only cover indictable offences and we do not have records of juveniles in our files. You might be able to get that information from other witnesses, Mr. Chairman.

Senator LEGER: Would any of those 54 juveniles that you mentioned be in school at that time?

Commissioner NICHOLSON: I am not absolutely certain but I do not think so, and certainly if there were any it was a very small part of the 54. I do not think that any of the 54 were in school at the time.

Senator HODGES: As you point out, the 54 juveniles that you list under twenty years of age have narcotic convictions. You do not take into account in your statement that there may be teen-agers of school age obtaining drugs without running foul of the law. In other words, is it not possible for some of them to get drugs without necessarily being convicted?

Commissioner NICHOLSON: Yes.

Senator HODGES: I ask that question because allegations are made so often in British Columbia as to that that I am anxious to get your views on the subject.

Commissioner NICHOLSON: Well, I think that if the habit spreads and youngsters were using drugs to any extent it would certainly come to the attention of our narcotic division in a number of ways, and this is merely one of them. I can be exact on this point of records because I refer to records, and from those records and from the general intelligence that comes in from our narcotic squads who are moving about all the time and working with these people and the handlers, who see them and know them, I am satisfied that it is not a problem. If youngsters were given drugs then those drugs must come from the handlers and in one way or another there would be some manifestation.

Senator QUINN: Have you a record of these teen-agers, of where they belong to?

Commissioner NICHOLSON: What part of the country they come from?

Senator QUINN: Would it be where the traffic is most prevalent, the addiction is greatest?

Commissioner NICHOLSON: Yes; there would be a relationship between the two. I do not know how significant it would be, because the numbers are so small.

Mr. LIEFF: In chart No. 1 you have been good enough to add to your memo figures for the years 1939 to 1945, and, of course, other figures. These all seem to be pretty low by comparison with other years. I wonder if there are any comments you would like to make in connection with that period of time,—whether the war had anything to do with it; or something of that nature?

Commissioner NICHOLSON: Yes. I think the war had an effect. It must be remembered, not only as far as Canada was concerned but generally, shipping was very restricted and controlled during the war, making it more difficult for the drug to flow; and I think that must have had some effect. Other things, I think, arose from the war which would have an effect on the traffic. For instance, there was registration; employment was at a high level; many people were in the armed services. All these, I think, had some effect. The high figures you notice early in the twenties, in the first three years, arise from the then rather common use of opium and the pretty extensive nature of addiction of that sort amongst Orientals.

Senator HODGES: That has died out a lot, has it not?

Commissioner NICHOLSON: Yes.

Senator HODGES: I think, with the growing up of the younger generation of Chinese, much of that habit has died out. We have found that to be so in the West.

Commissioner NICHOLSON: The old Oriental drug addicts were people who brought the habit with them.

Senator HODGES: That is what I mean.

Mr. LIEFF: That seemed to have died out in the middle twenties.

Commissioner NICHOLSON: That is right.

Mr. LIEFF: It has not been a problem since then to any great extent?

Mr. NICHOLSON: There was opium in use later on, but there was a gradual drop-away from it to morphine, and from morphine to heroin.

Mr. LIEFF: On page 8 of your presentation there is a very interesting sentence at the end of paragraph 2.

"However, profits are so attractive that the gaps caused by arrests are quickly filled by other criminals and the traffic continues."

I suppose there is always another organization ready to take over this good business.

Commissioner NICHOLSON: Yes. There is the market; there is the money; and it will not be overlooked by criminals.

Mr. LIEFF: Well, then, is there an incentive to crime in the process of getting to the top by these people who want that profit?

Commissioner NICHOLSON: Wars between different gangs?

Mr. LIEFF: Yes,—what is commonly referred to as "muscling in" and "taking over", that sort of thing?

Commissioner NICHOLSON: There is some of that, yes.

Senator HOWDEN: I take it your private personal opinion is that the users would have to be gathered up and incarcerated in an institution of some kind, and treated, and then there will be a definite falling-off in the traffic. Is that so?

Commissioner NICHOLSON: That is so.

The CHAIRMAN: Any other questions you would like to ask Commissioner Nicholson? If not, may I express our sincere thanks for him for coming before us.

Hon. SENATORS: Hear, hear.

The CHAIRMAN: May I draw to the attention of the Committee that when we stand adjourned in a few minutes we shall meet at half-past two today to hear two witnesses and see the showing of a film, "The Drug Addict", at 2.30, in room 368. The two witnesses we are to hear this afternoon are Mr. Hossick and Dr. Roberts. Mr. Hossick is Chief of the Division of Narcotic Control of the Department of National Health, and Dr. Roberts is Chief of the Mental Health Division of the Department of National Health.

Mr. LIEFF: May I call the attention of the Committee to a piece of literature which was placed on the table the other day, entitled "Arguments for and against the legal sale of narcotics", by Dr. G. H. Stevenson, who has done a lot of work on the problem. I wonder if all members of the Committee got it.

Senator HODGES: It was sent to us.

Thereupon the Committee adjourned until 2.30 p.m.

The committee resumed at 2.30 p.m.

The CHAIRMAN: Honourable senators, would you please come to order. Our first witness this afternoon is Mr. K. C. Hossick, Chief of the Division of Narcotic Control of the Department of National Health and Welfare. Incidentally, I would point out that the proceedings this afternoon will not be too long. Following Mr. Hossick's presentation we are to be shown a film. Following the presentation of the film we will have evidence from another witness, whose testimony will last for only fifteen or twenty minutes. I would now call upon Mr. Hossick.

Mr. LIEFF: Mr. Chairman, with your permission, may we have placed on the record a word or two about the length of service of Mr. Hossick. I understand he has been in the Government service for some forty odd years.

The CHAIRMAN: Yes.

Mr. HOSSICK: Mr. Chairman and honourable senators, my continuous Government service dates from August, 1914, and includes my overseas active service of five years; nine years active service as an officer of the R.C.M.P., and some twenty-seven years in the Division of Narcotic Control; eighteen years as the Assistant Chief and, in the past nine years, as the Chief of the Division.

I should like to tell you this afternoon something about the administration of the Opium and Narcotic Drug Act, which is the responsibility of the Division of Narcotic Control of the Department of National Health and Welfare. This Division is also the agency through which Canada gives effect to her international obligations for the control of the distribution of narcotic drugs. The criminal enforcement of the Act, however, is carried out through a working arrangement with the Royal Canadian Mounted Police, the only federal enforcement agency in Canada. The degree of integration of effort between this Force and the Division of Narcotic Control provides an excellent illustration of co-operation between two agencies of Government.

Canada's legislative approach to narcotic control differs somewhat from that of other countries. It combines in a single law both the administrative aspects for the control of narcotic drugs for health purposes and the criminal aspects concerned with the anti-social or illicit use of narcotic drugs. This dual legislative approach to the problem is, moreover, administered by that department that is charged with matters relating to the health and welfare of the people of Canada.

The Opium and Narcotic Drug Act provides a simple but efficient method of handling the distribution of narcotic drugs for the purpose for which they should be used. Included in the administrative machinery set up under this act are penal sanctions designed to make violation of the law unprofitable.

The jurisdictional basis of the Opium and Narcotic Drug Act is clear and simple. It is criminal law and, as such, is within the exclusive competence of the Parliament of Canada and has application everywhere in Canada, without regard to provincial boundaries.

The Criminal enforcement of this law, important though it is, does not constitute its whole purpose. Dramatic as the enforcement aspect is, domestic control of narcotic drugs is perhaps the most important element in the administration of the law. It is through this control, in co-operation with legitimate distributors and users of narcotic drugs, that Canada endeavours to keep the narcotic problem to relatively small proportions.

In this connection, Canada has enacted simple but effective laws and regulations designed to limit exclusively to medical and scientific purposes the manufacture, sale, import, export, distribution and use of narcotic drugs and narcotic products. Narcotics in Canada are as scrupulously handled, audited, recorded and protected as the funds in our government-chartered banks.

Canada regularly furnishes the established international supervisory bodies with detailed information respecting existing narcotic problems and measures taken to control drugs within the Dominion. For example, an estimate is submitted annually, well in advance of the ensuing year, of Canada's narcotic requirements for medical practice. The Secretariat of the United Nations is also advised of quantities of narcotics contained in imported or exported medications, as well as of the amounts of all important drugs used for medical and scientific purposes.

As Canada does not manufacture basic narcotics but must import them, an important responsibility of the Division of Narcotic Control is to insure that adequate quantities of narcotic medication are always available for medical needs. The fundamental principle upon which domestic control is predicated is that no narcotics or preparations containing them may be imported except under licence from the division, nor may they be distributed except through licensed firms.

Wholesalers and druggists must maintain records of all drugs handled, showing the dates of transactions and the names and addresses of all persons concerned.

Perhaps at this time I may refer you to the register, which I see most of you have. This is a register which is in every retail drugstore in this country, of which there are some 5,000. The first part of it contains the register of sales, and the second half of it contains the register of receipts. Many years ago it was only possible for the division to obtain reports from retailers on a basis of approximately three months out of the twelve months, for the simple reason that at that time the retailers had to write out in long-hand on special forms from the register which they kept, the report which they submitted to the division. We felt that this was a hardship, and so we designed this book, which has been hailed by the drug trade as one of the best type of registers they have ever had. It is on a duplicate page basis. That means that when the sales entry is made in the register it is made only once, and when those sales reports are called for—and we call for them every quarter—it is only necessary to tear out the original page and the duplicate page remains as the druggist's permanent record, which is available then for inspection by inspectors who inspect from time to time.

Senator HODGES: Are sleeping tablets, and such items, included in the register?

Mr. HOSSICK: No; they do not come within narcotic jurisdiction.

Separate records must be kept for each branch or store. Physicians, veterinary surgeons and dentists must provide information, when requested, respecting drugs received, dispensed, prescribed or otherwise distributed. Records must be kept by anyone who maintains premises in which drugs are kept, and a high standard of security is at all times insisted upon.

Licensed wholesalers—of which there are between 150 and 160 at all times—submit monthly reports on sales of drugs, and the division maintains on individual cards a record of drugs received by all hospitals, physicians, dentists, veterinary surgeons and retail druggists.

Then, if you will look at this triplicate form. This is the type of report that comes from wholesalers each month. Some wholesalers, I can assure you, when the monthly reports come in to the division, submit a report which is probably two to three inches in thickness—this will give you some idea of the numerous transactions which go on between the various professions and the wholesalers. This form has been designed within the last two years. The triplicate remains with the wholesaler, and the original and duplicate comes to the division. It is a perforated type form and is suitable for pre-sorting. Detailed entry of each item is then made on cards, specimen of which I have

here. You have the yellow cards in front of you. We again utilize these slips, which go out to our inspectors in the field, so that they will know at a glance the particular category and the amounts of each drug which are being purchased at any one time by retail pharmacists.

Only members of the various professions, that is, physicians, dentists, veterinary surgeons and retail druggists who are in good standing with their respective provincial associations may sell, purchase, issue or prescribe drugs, and a constant check ensures that others do not do so. Drug quantities received by authorized persons are watched, and amounts apparently excessive must be explained. In the Division of Narcotic Control, we keep ourselves particularly advised of all those new members, new graduates, new licence holders, and people who are transferred from one province to the other, so that at all times we can tell exactly where a medical man is in the province and whether he is or not in good standing.

The CHAIRMAN: Are drugs defined by their regular names?

Mr. HOSSICK: Drugs are defined in the schedule to the Opium and Narcotic Drug Act.

Senator BAIRD: But you cannot stop the quantity that any doctor can get, can you?

Mr. HOSSICK: We do lay down a rule that they should not be supplied with more than one ounce of any one drug in any one month. Very few physicians need that quantity. I will be coming to that in a moment.

Wholesalers also submit reports on the quantities of drugs on hand at the end of each year. These statements, with the import and export data, are used in estimating drug consumption and also in preparing estimates to the Permanent Central Opium Board. Provision is made, of course, for adequate reserve stocks, and we endeavour, in co-operation with licensed narcotic wholesalers and importers, to maintain a one year reserve in the country at all times to provide for any emergency.

The division's staff of trained auditors, who are qualified pharmacists, examine the books and records of wholesalers, retail pharmacies and hospitals to ensure that they are kept satisfactorily, and audit the stocks and manufacturing procedures of all wholesale houses in Canada.

As an additional check on the distribution of narcotic drugs, no wholesaler—and this is the question the honourable senator asked a moment ago—may sell to any authorized person, whether physician, dentist, druggist or veterinary surgeon, straight drugs in quantities exceeding one ounce of each drug per month, without special permission. It is only where the purchaser is able to explain satisfactorily the reasons for additional amounts as, for example, a large drugstore,—such as one of the drugstores in a medical arts centre,—or a physician specializing in cancer, that special authority is given; and it is regularly given if the request is legitimate.

The CHAIRMAN: Where are these drugs obtained?

Mr. HOSSICK: From wholesale sources. Most of our supplies are imported, from Great Britain, some from India, and some from the United States.

The CHAIRMAN: Do you check up on the supplies, too?

Mr. HOSSICK: Oh, definitely. They only come in to the country by means of import licences, issued within the department.

Senator McDONALD: Does this include codeine?

Mr. HOSSICK: It includes codeine.

Senator McDONALD: Has there been any regulation as to codeine from a drugstore?

Mr. HOSSICK: It can only be purchased from a drugstore in a very small amount, an eighth of a grain to the tablet, or a third of a grain to each fluid ounce.

Senator McDONALD: That can be obtained without doctor's prescription?

Mr. HOSSICK: Without doctor's prescription.

Statements on drug sales are also received from retailers, showing purchases by hospitals, physicians, veterinary surgeons and dentists, as well as drugs dispensed on prescription. Should the quantity of drugs appear excessive, explanations are required.

When it becomes evident that narcotics are being used illegally, by a professional man, criminal proceedings, if necessary, are undertaken. Retailers' reports also facilitate checks on the handling of drugs by unauthorized persons and reveal cases where drugs are being obtained illegally from more than one physician, contrary to the Act.

Senator McDONALD: Has there been any change in that regard lately?

Mr. HOSSICK: Not in that regard. We have gone a little further with regard to prescriptions in the new regulations under the Opium and Narcotic Drug Act. We now allow for the oral prescription of a physician to a drug store.

Senator McDONALD: I think that is the change.

Mr. HOSSICK: That is the change that has taken place. I may say that that change was requested not only by the medical profession but by the profession of pharmacy. There was previously some difficulty in regard to telephone orders, but we now have no record of any abuses in that respect.

Senator HOWDEN: I was wondering about the matter of the reduction of codeine to one-quarter grain, when it is the least potent of all narcotics.

Mr. HOSSICK: Do you mean the free sale of one-quarter grain?

Hon. Mr. HOWDEN: Quarter grain codeine does not have anything like the effect of quarter grain morphine.

Mr. HOSSICK: I appreciate that, but we are following the recommendation of the medical profession, as well as the Colleges of Pharmacy. Whenever the medical profession is prepared to change that recommendation, I can assure you, sir, it will be given every consideration.

Senator HOWDEN: I can't imagine the medical profession making the recommendation, but I take your word for it.

Mr. HOSSICK: As a matter of fact, I might recall that when I was before the National Health Committee—and I think you were a member then, Senator Howden—that very question came up, and the recommendation of the medical profession that the exemption should be one-eighth to the tablet passed without comment.

Senator HOWDEN: I believe the attitude of the medical profession is that they just don't bother to use codeine anymore, except in cough mixtures and things of that kind.

Mr. HOSSICK: That may be so. If you are interested, I can tell you the extent of the use of codeine in Canada.

Senator HOWDEN: But codeine is a most unsatisfactory drug; it is desperately constipating, and does not have the active qualities of morphine.

Mr. HOSSICK: It is used to the extent of almost 80,000 ounces a year, as compared with 5,000 ounces of morphine, by the medical profession.

Senator HOWDEN: By reason of the fact it is an element in all cough mixtures to control the cough.

Mr. HOSSICK: It is used to a great extent in cough preparations. From the standpoint of public relations, much has already been accomplished in Canada, in the professional field, through specially prepared lecture material presented to medical and pharmaceutical associations and schools of nursing, also to undergraduate societies in colleges of medicine, pharmacy, and nursing, by bringing before these professional groups pertinent facts on the economic and social aspects of drug addiction. This type of public relations approach has, over the years, resulted in a better understanding of control procedure in the handling of legitimate stocks and the use of narcotic medication in the practice of medicine and pharmacy. As a result, Canadian control authorities seldom, if ever, encounter legitimate supplies in underworld circles, and I am very proud, Mr. Chairman, in being able to publicly make that statement.

I also believe Commissioner Nicholson made reference to that fact this morning, that seldom do we encounter legitimate supplies in underworld circles.

Senator HAYDEN: May I ask a question? Are the drugs labelled in such a way that you can distinguish whether they come from legitimate or other sources?

Mr. HOSSICK: No. Let me put it this way: The control we exercise over the wholesale and retail outlets, and the constant check that is maintained, clearly indicates to us that there is a covering order or prescription for practically every grain that is sold. Our auditors constantly audit the wholesale procedures as to the drugs that are going out in the manufacture of various narcotic products, and we have a close check on retail outlets and on hospitals.

Senator HAYDEN: What you are assuming is that your control system is foolproof to the extent that there can't be a leak.

Mr. HOSSICK: Shall we say, we think it is very good. I don't think there is anything foolproof.

Senator HAYDEN: I agree with you on that point.

Mr. HOSSICK: While vigorous enforcement is essential to suppress the illegal use and distribution of drugs, it is fully recognized that enforcement alone will not solve Canada's drug problem. In my own personal opinion, enforcement must be accompanied by a more general recognition of the causes of drug addiction by the establishment of adequate treatment facilities for persons who have become addicted together with some preventive measures against the spread of the contagion of addiction.

Mr. Martin, in his initial presentation before this Committee last week, referred to the fact that many experienced enforcement authorities had put forth a suggestion as one offering the most practicable and realistic approach to the solution of the drug addict.

This involved the establishment of treatment institutions, with legal authority for the committal and detention of addicts for such period as would be necessary for their treatment and rehabilitation. He further explained that this would require the legal right to return to an institution any addict who had been released on discharge and who had subsequently reverted to addiction to drugs. In my own personal opinion, I would subscribe to this suggestion.

Senator HAYDEN: May I ask a question there? The experience in the Toronto jails over a period of years, I think, has been that the best method of dealing with a drug addict is to take him off drugs completely, and let him sweat out his period of suffering. He eventually reaches a stage of rehabilitation. I believe the difficulty arises in what may happen to him when he is released. If he is released into the surroundings in which he was found and apprehended, he quickly acquires the habit again.

Would you not subscribe to an enlargement of the proposals that are outlined here, namely, that there must be some element of control—something in the nature of probation? In that way an addict would, for a great many years after he had apparently been rehabilitated, never get outside the purview of some supervising officer. Further, part of the program should be that he would not be returned to the area in which he contracted the habit.

Mr. HOSSICK: That is more or less what I mean by saying there should be an increased control. I think that is the very thing Commissioner Nicholson stated to the committee this morning.

Senator HAYDEN: Unfortunately I missed that, but I have been doing a little thinking myself.

Mr. HOSSICK: On the international level, I can assure this Committee that due to the action of the Canadian Delegation and with the help of some other countries, drug addiction has been given top priority in the deliberations of the United Nations Narcotic Commission. Three immediate steps towards the final goal have been stressed—international co-operation, exemplary and greatly increased penalties for the narcotic trafficker, and compulsory hospitalization in closed institutions for the addict. (This, of course, would include all features of rehabilitation, job placement and adequate follow-up procedures). I think that is what Senator Hayden had in mind.

Senator HAYDEN: As you know, I have had some earlier associations with this business.

Mr. HOSSICK: I am well aware of that.

Senator HAYDEN: And we were very successful in it.

Mr. HOSSICK: That is quite true.

I have given very briefly an outline of some of the administrative procedures involved in the administration of the Opium and Narcotic Drug Act, and I will, of course, be glad to enlarge further on any specific matter within my jurisdiction should any member of this Committee so desire.

I also understand that your Chairman, Senator Reid, has set a date for a visit to my Division by this Committee, namely, Tuesday morning, March 29th, when I hope to have the opportunity of showing to you in complete detail the administrative control machinery in operation.

Mr. LIEFF: Mr. Hossick, you have gone into some detail in regard to control in the handling of narcotics. Would you be good enough to tell the committee what has been the experience of other countries in this type of control? I am particularly interested in the control exercised in the United Kingdom.

Mr. HOSSICK: Well, I believe you will have as a witness someone from the United Kingdom, who can tell you more than I can. As a matter of fact, there are some things which we in Canada would like to know more about. I think I can tell you, however, that their per capita consumption of narcotic drugs is greater in some cases than is ours, and yet they do not record having as many drug addicts as we do. What the reason for that is I am afraid I cannot tell you. I can tell you this however, that they have not got this type of record system in the retail drug stores of which I think there are some 16,000 or 17,000 in the United Kingdom. They do not receive monthly reports from those people nor do they get reports from wholesalers and that may be where some of the difference lies in so far as the United Kingdom system is concerned. However, I am quite sure you will hear more about that when someone from the United Kingdom appears before this committee.

Mr. LIEFF: Thank you. You were saying something about your public relations program. Would you care to say a few words about your thinking

in connection with an educational program amongst young people. Perhaps you can also deal with that figure that we were given this morning by Commissioner Nicholson of 54 juvenile addicts. Have you any opinions on that?

Mr. HOSSICK: As I mentioned a few moments ago we feel very proud in the department about the public relations approach to the various professions. I think I can honestly say that the liaison which exists with the medical profession, the Colleges of Pharmacy, the dentistry and veterinary professions, as also the hospital associations in this country is very very close indeed. I receive letters almost daily from young medical men with problems that they wish to discuss with the department, people that I have actually met in the university during the last eight or nine years, and I feel this program has been a worthwhile effort.

Now, you ask me about the proposed educational program among young people. I would say that I do not think it would be a step in the right direction to institute an educational program among the youth of this country in regard to narcotics. This is particularly so when there just is no problem in regard to school children, teen-agers or even high school students in regard to narcotics. I feel, that from the standpoint of curiosity alone it would be a very bad thing to institute any such type of program. If, however, we had a problem of teen-age addiction then I would say that there would be some need for it, but I would shy away from any such type of educational program at present in Canada.

Now in regard to the figure mentioned by Commissioner Nicholson of the number of juveniles of whom he has criminal records. He said there were about 54 addicts under the age of twenty. He was telling you about addicts with criminal records. The figures which the Hon. Mr. Martin gave you last week in which he indicated there were 26 altogether, are given as of 1954. They are statistics compiled for the year 1954. In other words we still have Commissioner Nicholson's 54 but the addicts may be up into a higher age group from the number in the statistics that Hon. Mr. Martin gave. Does that answer the question?

Mr. LIEFF: Yes, I think so. I wonder now if we could turn to the table filed by the Minister, Table 1, in which he gave us three lists of addicts. Under the heading criminal he listed 2,364; medical, 515; and professional, 333. I wonder if you could throw a little light on the basis of the computation of these three figures particularly the first one.

Mr. HOSSICK: In the case of the first figure which comes under the heading of criminal and the total that the Minister gave you of 2,364, that figure is arrived at as a result of information which we obtain through the officers of the Royal Canadian Mounted Police and, on occasion, an odd one from some of the municipal forces. As I indicated before, and as Commissioner Nicholson has indicated to you, there is a very close liaison between our two departments. We keep very careful records of all of these cases, not only of convictions, but those who are known to be addicts, those who have previous criminal records and those who are coming into or joining the addict fraternity.

In the last few years, in addition to the number of addicts we have been trying to get down to a basis of getting some information on these people. We now have a punch card system—you have a copy of that in front of you—which illustrates the type of information which we are trying to get. These cards are not fully completed yet but they are well on the way to being completed, and when they are we can draw off almost at a moment's notice the actual drug population in Canada as it has been reported to us.

Now, in regard to that figure of 2,364 addicts the Commissioner this morning indicated that he had criminal records of 2,009. That makes a difference

of 355. That is easily explainable to this extent that the people that Commissioner Nicholson talked about are those who now have criminal records. The other 355 could be addicts whom we know about but who have not yet built up criminal records. I suspect however, if we dig down far enough we will find that the other 355 at least have some record of either juvenile delinquency or they have been problem children somewhere at one time or another.

Senator TURGEON: Did not Commissioner Nicholson say that 2,009 were those actually indicted?

Mr. HOSSICK: That is right.

Senator HAYDEN: It would appear from what you said Mr. Hossick that our problem in so far as drug addiction is concerned arises from the availability of a non-licensed supply.

Mr. HOSSICK: Correct.

Senator HAYDEN: Well, then, it would appear from the evidence we have so far that it is a case of illicit trade that develops to meet a demand that exists.

Mr. HOSSICK: To some extent yes.

Senator HAYDEN: In other words you have your addicts and you know to some extent the numbers, and the trade develops to meet that. I gather, too, that you would not be prepared to say that there is any course of education or any campaign to encourage people to become drug addicts so that they might sell more drugs.

Mr. HOSSICK: That is true.

Senator HAYDEN: Well then in that connection could you give me some idea what may be said to be the life span of an addict?

Mr. HOSSICK: I would prefer if that were dealt with by one of our medical authorities whom you are going to hear this afternoon, and I think you will appreciate that medical authorities would be in a much better position to answer that question.

There is however, no reason why an addict cannot take drugs and reach the age of sixty-five or seventy years.

Senator HAYDEN: I was not discussing that phase of it. The addicts as you ordinarily see them, their secret method of acquiring and using drugs to avoid detection leads to a series of infections and abscesses one after the other, so I thought in the light of that there might be some record. Have you any?

Mr. HOSSICK: Yes, sir. I have a record of age groups all the way up to seventy and over. We still have them at that age. In fact we have a fair number over the age of seventy.

Senator HAYDEN: You cannot depend on early death to terminate your addiction problem?

Mr. HOSSICK: I don't think so. As a matter of fact, we had a case just a very short time ago right in your own city where, after I think it was three years in the penitentiary, an addict died from an over-dose of the drugs in a matter of some twelve hours after leaving the penitentiary and getting back to Toronto.

Senator HAYDEN: That simply proves that illegal supplies of drugs are still available in Toronto.

Mr. HOSSICK: I think I can safely say that they are.

Senator LEGER: Could Mr. Hossick tell us how many people become drug addicts through sickness?

Mr. HOSSICK: I will have to take that in a sort of a two-stage way, bearing in mind that the vast majority of Canada's imports of narcotic medication go to the sick people of this country, people who are suffering from legitimate medical conditions. They do not form any part of this statistical information that you have been looking at.

Senator LEGER: None of them become addicts?

Mr. HOSSICK: Well, it is a question of whether they become used to the drugs they are taking or not. Sometimes you will get a case that comes within a medical category that has been obtaining narcotics for a good many years and the original medical condition may to some extent clear, leaving the addiction superimposed upon that old medical condition. But these people are not a problem to the enforcement authorities, they are under proper medical care. It is quite true that they develop into—what shall I say—medical addicts, and some of them could come within the other figure mentioned here, this 515 figure. They will shop around from physician to physician. But they are not, as a rule, problems to the enforcement authorities.

Senator HODGES: May I ask Mr. Hossick a question? Out of your long experience do you think there is any merit in this suggestion for clinics which would supply drugs free to addicts?

Mr. HOSSICK: No.

Senator HODGES: You don't think so?

Mr. HOSSICK: I can subscribe entirely to what the Royal Canadian Mounted Police had to say this morning and what Mr. Martin had to say last week. Last week I supplied you all with copies of Dr. Stevenson's recent pamphlet.

Senator HODGES: I have that.

Mr. HOSSICK: And I think he deals with that very, very well. As a matter of fact I take some credit for having urged Dr. Stevenson to publish that pamphlet at this time, because I felt that this was the right time for it to be published and for it to be brought to your attention. I would fully subscribe to what he says, to what Commissioner Nicholson says and what my Minister says about clinics.

Senator BAIRD: Would it not take the profit out of this business, and is that not worth doing?

Mr. HOSSICK: I think it would cause a terrific amount of headaches, and surely no one would suggest that it was treatment.

Senator BAIRD: But I mean to say, the main cause of this thing is that they are making a lot of money in trafficking in it.

Mr. HOSSICK: I don't think it would.

Senator McDONALD: It is encouraging to hear that teen-agers are not using drugs. That is true of the West Coast, is it?

Mr. HOSSICK: That is right. I would like to say for the purposes of the record that a lot of information has trickled into the Department over the years about certain people that might be suspected to be in the teen-age category of taking drugs or smoking marihuana. We never pass up any of that information, no matter how it comes to us, even if it is a telephone call or an unsigned letter; it goes to the police immediately, and I can assure you that the R.C.M.P. investigate the matter thoroughly. I know of one instance not so long ago, in Senator Hayden's city, where there was a rumour about the use of marihuana by high school children, and I think the Royal Canadian Mounted Police were on that case for almost three months before they found out that some boy had been reading some cheap literature, and I think he had been smoking dried leaves or something and telling everybody it was marihuana. I even believe he named the place where he had obtained it, and indicated the person who was supposed to be supplying this material. But it was completely fictitious. A lot of effort is put into these investigations; and I know they are all followed through to a successful conclusion.

Senator HODGES: I would like to point out to Mr. Hossick that we had press reports from time to time at Vancouver of the addiction of high school students to it. You claim there is no basis for these reports.

Mr. HOSSICK: We have not found it to be a fact.

Senator STAMBAUGH: Do you know of a case where a high school principal in the city of Edmonton made a statement to a reporter that high school students in his particular school were, he believed, drug addicts?

Mr. HOSSICK: I have not any files with me on that particular incident, sir, but I seem to remember something about it and from memory I believe. I can tell you that it was thoroughly investigated.

Senator STAMBAUGH: I understood that it was. I was wondering if that came down to Ottawa.

Mr. HOSSICK: I also have a feeling that last year the incident was mentioned in the House of Commons by a member, and he withdrew the remark, I believe, when he could not prove that it was a fact. I think that it had something to do with Edmonton; at least it was one of the Alberta communities.

Senator HOWDEN: Commissioner Nicholson this morning agreed rather that if we were able to shut off the demand for narcotic drugs we soon would not have any problem.

Mr. HOSSICK: Would you mind repeating that, sir?

Senator HOWDEN: Commissioner Nicholson agreed this morning that if we could shut off the demand we soon would not have any problem.

Mr. HOSSICK: I think that is right.

Senator HOWDEN: That is what you would say?

Mr. HOSSICK: Yes.

Senator HOWDEN: Then the place to start is at the demand, if possible?

Mr. HOSSICK: Right.

Mr. LIEFF: Do I take it that you are through with the first two columns?

Mr. HOSSICK: Yes.

Mr. LIEFF: Did you want to say a word about the third column? Or perhaps we could leave that to one of the physicians who will be here.

Mr. HOSSICK: You can, or I would be very glad to talk about the third category. There are 333 that were placed in the professional group.

Mr. LIEFF: By "Professional": you mean what?

Mr. HOSSICK: The professional category I refer to are those who have access legitimately to narcotic drugs.

Senator BAIRD: In other words, doctors—?

Mr. HOSSICK: Yes.

Mr. LIEFF: Nurses?

Mr. HOSSICK: Nurses and druggists.

I might say that the figure for physicians alone is somewhere in the neighbourhood of half the total figure in the professional.

Senator HODGES: What is the figure?

Mr. HOSSICK: Three hundred and thirty-three.

Senator HODGES: That is for the whole of Canada?

Mr. HOSSICK: Yes.

Senator HODGES: Mr. Hossick, is there any reason to believe or suspect that these doctors or professional men who are addicts might themselves be likely to supply illegitimate trade?

Mr. HOSSICK: I hardly think so. I think all of their effort would be in finding sufficient supplies from legitimate stocks for their own use rather than supplying anyone else.

Senator QUINN: Following up what Senator Howden has just said, would you go so far as to say that we might segregate all addicts, putting them in institutions and keeping them away from the outside altogether in order to cut off their supply?

Senator HOWDEN: You would have to have institutions in order to do that.

Senator BAIRD: And that costs money.

Mr. HOSSICK: If it could be done, I would agree with you.

Senator BAIRD: It is done in the United States, is it not?

Mr. HOSSICK: They have two large federal institutions in the United States, one at Fort Worth, Texas, and the other as Lexington, Kentucky.

Senator BAIRD: Have you visited the institution at Lexington, Kentucky?

Mr. HOSSICK: I have visited both.

Senator HODGES: All drug addicts in the United States are not confined to these institutions.

Mr. HOSSICK: Oh, no. The number of drug addicts in the United States is estimated at well over 60,000. The capacity of Lexington is 1,300, 1,000 male and 300 female. I think the capacity of the institution at Fort Worth, Texas, is somewhere around seven or eight hundred.

Senator HODGES: Are they volunteer inmates?

Mr. HOSSICK: Some are volunteer while others are there on probation. Some are transferred from the penitentiaries.

Senator HODGES: I suppose we can take it that the worst cases are transferred from the penitentiaries?

Mr. HOSSICK: I would not know that for certain.

Senator HODGES: If we wanted to isolate or segregate all the addicts in Canada the problem would be to segregate not only those who have been convicted in the criminal courts but all other addicts as well. That would have to be done in order to make the system effective.

Mr. HOSSICK: That is right.

Senator HODGES: Have you any knowledge of the number of addicts there are exclusive of the figures of those criminal addicts of which you have knowledge?

Mr. HOSSICK: According to the figure Mr. Martin gave you last week, the total of criminal, medical and professional addicts amounts to 3,312.

Senator HODGES: Do you think that covers the total number?

Mr. HOSSICK: According to our records which I have described that covers the number at the present time, yes.

Senator HODGES: Then you do not think there is any basis for the figures that have been quoted from time to time as 20,000 addicts in Canada?

Mr. HOSSICK: No.

The CHAIRMAN: Are there any other questions?

Senator HAYDEN: Mr. Hossick, if there are only a little over 3,000 addicts in Canada they must have a gold mine somewhere in order to find the necessary means to buy drugs at the prices which we were told by Commissioner Nicholson this morning were the going rate. I find it difficult to appreciate that 3,000 people could find such sources of supply of money to pay those prices day after day.

Mr. HOSSICK: They do manage to get the money and on the part of the male it is mostly by shoplifting and on the part of the female it is mostly through prostitution.

Mr. LIEFF: If I may just ask a question here, Senator Hayden. Mr. Hossick, how many of the 3,000 addicts are presently in jail or penitentiary?

Senator HAYDEN: The number you take out of circulation will only increase the difficulty in my problem.

Mr. HOSSICK: The number presently in penitentiaries I think totals 463. I cannot give you the exact figures of those who are in provincial jails. We do not get those figures. We have had no reason to ask that these figures be given to us, but I would venture to say that there are probably in provincial jails another 350 to 400 addicts.

Senator HAYDEN: So that you are talking about a market of possible purchasers for the drugs that are illegally sold of somewhere between twelve and fourteen hundred?

Mr. HOSSICK: That is right.

Senator HAYDEN: And that is at \$5 a shot?

Senator BAIRD: And it is said that three shots a day are sufficient to keep an addict going.

Mr. HOSSICK: I think Commissioner Nicholson will agree that was a rather conservative estimate he gave you this morning.

Senator HAYDEN: It is puzzling to me the amount of money that is required at the going prices in order to get these drugs, especially where it involves such a small band of people with no particular training except their ability to pick pockets and steal merchandise in stores. And there must be a limit as to what they can do there. Where do they get the money?

Senator HODGES: Do you not think that addicts obtain substantial sums of money through armed holdups of banks and that sort of thing?

Senator HAYDEN: I do not think you will find drug addicts robbing banks.

Mr. HOSSICK: I do not think any drug addicts take part in violent crimes and holdups.

The CHAIRMAN: The Chief of Police of the city of Vancouver will appear before this committee as a witness. In speaking to him before I came to Ottawa he said that a great deal of crime in Vancouver could be traced to drug addicts. Are there any other questions; if not I am going to ask Mr. Hossick to present his film.

Senator HODGES: I think we should thank Mr. Hossick for his presentation, which has been most interesting and enlightening.

The CHAIRMAN: Yes. I was going to do so after the presentation of the film. We do want to thank you very much, Mr. Hossick, for your splendid presentation.

Mr. HOSSICK: Mr. Chairman and senators, the film you are about to see is entitled "Drug Addict", and was made about seven or eight years ago. It was produced by my department in co-operation and collaboration with the Royal Canadian Mounted Police. It concentrates primarily on the so-called criminal addict, that is, the addict who obtains his drugs mainly from illegal sources with funds usually obtained by contravention of the law and at the expense of society.

At this stage I should like to draw your attention to the fact that in presenting the various sequences in the film we have endeavoured to simplify to quite an extent the manner in which narcotics are distributed. Actually, illicit distribution is by no means as simple in all cases as it is portrayed in the film.

We have tried to show something of the addict's way of life and his pursuits, and we have done that, I believe, with some realism, for the people who appear as addicts are actually addicts. The settings are also real and representative. They were "shot" mostly in Montreal but could just as well have been filmed in any of our principal cities.

The film, when it was made, was intended to give those who are not informed about the drug traffic and who are not familiar with addicts and the demands of their compelling habit an insight into this element of our criminal population. It is a documentary film about real people leading their real and very tragic lives.

We have found this film to be of great use in public relations work amongst professional groups. We have also found it to be of great use, as I think the R.C.M.P. will attest, in the training of enforcement personnel. It is still a restricted film, although there was a short version made of this film for public showing. After you see the picture I think you will agree that we honestly tried to show something about the criminal addict and the way he lives from day to day, and I think Senator Hayden will appreciate some of the methods used by some of the addicts in order to get the money with which to buy their drugs.

(The film "Drug Addict" was then shown to the committee members.)

The CHAIRMAN: Mr. Hossick, we appreciate the film you have shown us. I am sure we have all been interested and found it most educational.

Our last witness for today will be Dr. C. A. Roberts, Chief of the Mental Health Division.

Dr. C. A. ROBERTS, M.D., *Chief, Mental Health Division, Department of National Health and Welfare, Ottawa, Ontario*: Mr. Chairman and honourable senators, perhaps I should first say that I graduated in medicine in 1942, that I have had four years experience as Superintendent of a hospital for the Mentally Ill; and a year as superintendent of a general hospital; and since 1951 have been with the Department of National Health and Welfare, as Chief of the Mental Health Division.

Before attempting to indicate how little I know about drug addiction, I might say that before coming to Ottawa, having had my education in Halifax, and then being in Newfoundland for five years, my experience with addicts was with a few professional people who became addicted, and a few patients to whom drugs were administered in the course of illness, and, their illness having been subsequently cleared up, remained addicted to the drug. Some of these people were successfully treated and were withdrawn from their drugs and finally were able to return to living without the chemical support that the drug provided.

In 1951 when I came to Ottawa, I found there was a problem of drug addiction in the large centres associated with a criminal group, so that my observations of the criminal group have only been over a period of three years. When it was suggested that I appear before this committee it did not seem to me advisable to prepare a special statement, but rather to try to give you some of the thoughts I have had over the past three years as I have attempted to familiarize myself with this particular health problem.

Mr. Chairman, I have tabled three papers, which I selected from a number prepared during the past three-and-a-half to four years. I would like to read from one of these papers, which was prepared last summer for delivery at the Fifth International Congress on Mental Health.

The subject of drug addiction has long been confused by very strong opinions and seldom clarified by research objective thinking. It is with con-

siderable hesitancy that I approach this discussion today. At times during the past three or four years I have felt that I knew something about the subject, but more recently I have been impressed by the absence of almost any factor regarding which there is universal agreement.

During recent years it has become increasingly clear that terms being used must be defined in order to avoid misunderstanding and misinterpretation of one's remarks. For the purpose of this discussion, drug addiction is limited to addiction to those drugs which are listed in Canada and the United States under Narcotic Acts and which, from a legal point of view, are apparently considered to have similar undesirable effects.

I feel that it should be pointed out that medically there is considerable difference between addiction to cocaine and to marihuana. These drugs are taken for the exciting effect they have and, marihuana particularly, by people who feel the need for a lift in much the same way as people take an extra social drink in order to relieve themselves from restraint which they would otherwise feel, but the next day they can go without it.

Senator BURCHILL: What about cocaine?

Dr. ROBERTS: It is more liable to produce addiction. But in the history of cocaine, it appears that the physicians who used it early, many of whom became addicted to it, overcame the habit without too much trouble. Cocaine was thought at first to be non-addicting when it was introduced into medicine.

For practical purposes in this country we are speaking of addiction to heroin on the one hand, and demarol on the other. In the illicit market heroin is the drug of choice whereas in the professional area it appears that demarol is the most widely used narcotic. By addiction it is meant that a person is given to or is using one of these drugs in a way which is considered to be detrimental to himself or others—that is, in a way which is socially unacceptable and which may possibly interfere with his physical and emotional health. No attempt is made to separate those addicted people who are using large quantities of drugs which result in the presence of measurable physiological changes from those who are using very small quantities of drugs where physiological changes can be demonstrated, if at all, with great difficulty and who are frequently referred to as having the "needle habit".

Senator HOWDEN: May I ask if demarol is a synthetic?

Dr. ROBERTS: Yes, it is.

During recent years there has been a concerted effort to bring about the recognition of drug addiction as a medical problem. This has also been true of many other conditions which occur in our society, such as alcoholism, venereal disease, etc. It appears important to clarify the objectives which it is hoped will be obtained by the recognition of these conditions as medical problems. It is possible that we are frequently misunderstood and make serious errors in our effort to gain support for our programs because we use such brief statements as "drug addiction is an illness" without further clarification. On many occasions it has been brought to my attention that the treatment of some individuals suffering from drug addiction has not been made easier but rather more difficult because of this term as the individual is now able to say "I am sick, it is not my fault and I am different from other people". It is common knowledge that the drug addict gives the impression that he considers himself somehow superior to the alcoholic, and that the regular and hardened criminal feels he is certainly different from either the addict or the alcoholic. The addict does not wish to associate with alcoholics when they are confined to the same institutions although it does appear that the same individual may, in fact, be both. It is apparent that a large number of these individuals have been alcoholics at one time and opiate addicts at another. I am sure that all of those

responsible for the development of these programs need much more than the statement "drug addiction is an illness". Surely we must mean to imply that drug addiction is an illness; that treatment programs can and should be developed for this condition, and that society and the individual have a responsibility to ensure that these morbid conditions are adequately treated and prevented.

It would be interesting indeed if someone could study in detail from all available sources the attitude of legislators and professional people toward these conditions. In Canada, during the past century, as separate facilities for the care of the mentally ill have been developed, those responsible for the legislation governing these separate facilities must have had some conviction regarding the problem of alcoholism and, in some cases, the problem of drug addiction. Almost all of our mental health legislation provides for the hospitalization and treatment of alcoholic habituees; and, so far as I am aware, the only legal requirement is that the patient's condition be primarily due to or associated with the use of alcohol. This legislation going back over many decades provides for either the voluntary admission or certification of persons where the use of alcohol is the predominant cause of the condition which now requires treatment. In four provinces of Canada, provision was made for the treatment of drug addicts in the same way. This certainly implies that those responsible for the legislation had some feeling that drug addiction was, like mental illness, a condition which required treatment and which could be cared for better in hospitals than in other places of confinement, such as jails or penitentiaries. In none of these areas however were really successful and fruitful programs for the treatment of either drug addiction or alcoholism developed.

Senator HODGES: Would you please give the names of the four provinces to which you referred?

Dr. ROBERTS: The provinces of Alberta, Ontario, Nova Scotia and Newfoundland.

Senator HODGES: Not British Columbia?

Dr. ROBERTS: No. Is it not possible that recognition of these conditions as an illness led to the development of medical programs which were not supported by the necessary social and community aids to treatment? One might add that only in recent years has this aspect of psychiatric treatment received real recognition, and in some areas the development of real community programs has lagged sadly. In the past few years programs have been developed for the treatment of alcoholism and in all of these it is obvious that medical and psychiatric treatment is only one aspect of the therapy made available to the alcoholic. This medical-psychiatric treatment is supported by programs of individual re-education, community education, and what might be described as social therapy. In only one or two places has an attempt been made to treat drug addiction in the same way. A few years ago it was not uncommon to hear psychiatrically trained physicians state that they could do nothing for the alcoholic; that many of the alcoholics did not really want to be treated and that this problem was one for which psychiatrists would sooner not assume responsibility. This attitude is now changing any many of our hospitals are quite successfully providing the medical part of the treatment program in co-operation with A.A. and Alcoholism Foundations. Today however one hears that the person addicted to drugs is a most difficult individual, does not really want treatment, has never amounted to anything before becoming addicted and that he cannot be satisfactorily treated except in a custodian institution with legal compulsion provided. This may or may not be true but one wonders if it would not be highly revealing to have a treatment program similar to those developed by the alcoholism foundations as an experimental approach to the treatment of drug addiction.

I might enlarge on this a little. All of us who have made contact with the programs in the United States, and have talked to people who have made isolated attempts in this country to treat drug addicts, have developed a very definite opinion that compulsion is necessary in its treatment. But some people advocate the desirability of a voluntary type of program, and some such programs have been started. The most recent, and perhaps the best developed voluntary program, has been sponsored by the State of Illinois. In Chicago, the state set up three community clinics located in general hospitals, and they arranged that the addict would be withdrawn from his drug, either at Lexington, the U.S. P.H.S. hospital; or in one of the general hospitals, or perhaps his dose was so low that he could be taken off without being institutionalized. I received yesterday a report of the last full year of service, and will attempt to obtain enough copies for distribution. It appears quite obvious now that the program will not be too successful; roughly two-thirds of the addicts who came for treatment withdrew in a short period of time, saying they did not want to carry on with the treatment, and presumably they went back to their former way of life.

Senator BAIRD: What would the treatment consist of? The cutting down of the drugs?

Dr. ROBERTS: No. They base it on the patient being off the drugs, either through an institution or by having him discontinue taking drugs. Many of the addicts take so little that there are no severe visible symptoms of withdrawal. The need is a psychological one which influences them in their demand for drugs. The program was to have been medical, psychiatric, and social—to provide individual psychiatric treatment when necessary, to provide social work with the family, and to try to involve them in a social and civic group and keep them at work—that is, to give them a lot of supportive therapy. However, it does not seem from the report which has just come in that it was a very successful approach.

It appears that our recognition of drug addiction as a medical and social illness could do much to overcome some of the social problems which presently exist because of drug addiction. It does not seem that a successful program can be developed unless both factors are taken into account. The institutional treatment programs developed to date are very difficult to assess but it does not seem that they have produced any dramatic favourable results. These programs have usually been isolated from the community and this may account for the apparently low rate of successful treatment. As with all problems of rehabilitation, it would seem highly desirable to organize programs which keep the individual in as close contact as possible with the local community. This means that services have to be developed at a local level and it seems doubtful that the development of a centralized institutional program in the absence of local services is warranted by the present extent of drug addiction as a social medical problem. If, however, ways can be found either to have a centralized institutional program combined with local rehabilitation activities, or alternatively local rehabilitation programs with local arrangement for institutional care when necessary, it would seem that the time has come when something should be done particularly in those areas where drug addiction is prevalent.

I understand, Mr. Chairman, you will probably be hearing from Dr. Isbell of the Lexington Institute. I might say a little about the result of treatment at that institute. There are two ways one can follow up drug addicts. One, a negative approach; namely, that so many patients have been discharged, many of whom are heard of, and a great many never heard of again, the latter group, you can presume, must have gotten along all right. On that basis fairly attractive results can be shown—around 50 per cent.

But the first positive follow-up which was attempted established an effective result of 15 per cent. They could locate only 15 per cent who were off drugs and doing fairly well. More recently they have conducted another follow-up, and the results are that approximately one-third do reasonably well after treatment.

Senator HODGES: Is that one-third of the 15 per cent or of the whole number treated?

Dr. ROBERTS: That is one-third of those treated.

It is well known that drug addiction occurs almost exclusively in those who have comparatively ready access to drugs—we therefore see drug addicts to a varying extent amongst certain professional groups; in patients under medical care and in certain members of our population who frequent areas where illegal drug supplies are available.

As far as the professional group is concerned, it would seem that improved education regarding these drugs is necessary. A most progressive step would be recognition by professional people who are becoming addicted, or by their professional colleagues, that more acceptable resources than drugs are available to them. These professional persons have a good many resources which can be utilized in treatment and we should encourage them to seek help when they find themselves in difficulty.

It would also seem desirable for professional persons administering drugs to patients to be much more familiar with the way in which addiction develops, and the signs of dependency, so that other methods of treatment can be applied before their patients become addicted.

The largest group of drug addicts, however, are those who obtain drugs from illicit sources and who apparently have not been introduced to these drugs through medical treatment. Many attempts have been made to classify these individuals from a psychiatric point of view but such classifications have not been too revealing. It does appear that most persons who become addicted have some characteristics which would allow them to be classified as other than normal or average personality make-up. We do not know that these people are in any way different from other psychopathic or inferior neurotic individuals who do not use drugs, or whether they are similar or different from those people in our society who are alcohol abusers. We know that many more individuals use alcohol because it is more readily available and therefore the classification of alcohol abusers from psychiatric point of view would probably show some differences from those who use opiates. More significant than the attempts to classify these people from a psychiatric point of view is a review of their personal history prior to the age of twenty. Here we find that the family situation and educational history can be considered as variants from the normal patterns. It does seem that the development of a better mental health program in our schools, awareness not only of the individual's make-up but of the social conditions under which he is living, would enable us to re-direct these children before they begin to frequent areas in which drugs are available.

It also seems that drugs are available only in selected areas of our cities and that these areas are characterized by the existence of slums, cheap boarding houses, taverns and restaurants which are well below acceptable standards. It is in these substandard areas that most of the socially undesirable members of our society congregate. It seems probable that improvement of these areas will seriously interfere with the distribution of illicit drugs. This interference must be combined with control, as far as possible, of illicit drug supplies.

Periodically there is a flurry of activity by groups of individuals who feel that the proper treatment of drug addicts would be to register them and

supply them with maintenance doses of drugs. It has been demonstrated that all of these drugs have certain physiological effects on the individual and that these individuals are psychologically different when they are under the influence of drugs. It is difficult to believe that responsible groups can advocate the maintenance of an abnormal physiological state or the chemical support of individuals in an abnormal psychological condition. All drugs, when taken in certain dosages become toxic and from a psychological and social point of view the quantity of drugs taken by an addict is toxicous and harmful to society. Even though the main justification for such a program is the absence of techniques which will successfully enable us to treat all addicted persons, we must surely continue to study these conditions and attempt treatment by more acceptable means.

In conclusion I would like to emphasize my belief that drug addiction is a medical, psychological and social illness. Such recognition implies that, as with all other illnesses, the individual and the community have a responsibility for the initiation of adequate programs for treatment and prevention. There are indications that it is possible to do a great deal for the addict if medical, social and rehabilitation methods are applied in a coordinated way. It seems that the prevention of drug addiction will require expansion of our school mental health programs so that variations from acceptable behaviour can be detected and treated before the opportunity for addiction to drugs has been presented. It does not appear that the medical and social services can develop an adequate program of treatment and prevention until the community can emotionally accept its responsibilities as well as an intellectual understanding of the factors involved. A successful program for the prevention and treatment of drug addiction will require concerted community, social action to remove from our cities those areas in which drugs are available, to provide adequate opportunity for our youth, and the emotional-social atmosphere which allows genuine rehabilitation efforts on behalf of treated drug addicts.

Mr. Chairman, I thought if I went through that paper first I would give you some indication of my thinking on this subject, and then I could answer some questions.

Mr. LIEFF: Dr. Roberts, would you allow me to direct your attention to a paragraph in the presentation delivered last week by the Minister of National Health and Welfare? I do not know whether you have seen it, but perhaps I can read it to you. At page 20 of his brief the minister said this:

There is a further suggestion which has been advanced but is not one made in the report which I have referred to. It is, however, one that has been put forth by many experienced enforcement authorities as offering the most practicable and realistic approach to the solution of the drug addict. This involves the establishment of treatment institutions with legal authority for the committal and detention of addicts for such period as is necessary for their treatment and rehabilitation. It would require the legal right to return to such institution an addict who had been released on discharge which, in turn, recognizes that a certain number of addicted persons might be more or less permanent inmates in that little hope could be held out for their successful treatment.

Dr. ROBERTS: In commenting on this particular paragraph I would like to just say that I am speaking as a physician with no knowledge and certainly not much understanding of jurisdictional responsibilities, legal requirements and so on.

Mr. LIEFF: Shall we say that we agree that we shall not hold you responsible for any constitutional or legal problems.

Dr. ROBERTS: It does appear when you talk to these addicts and visit those institutions which have been set up and see the rather peculiar, almost special

life, that these people live that it might be helpful if we could consider it, as indicated again in this film we have just viewed, as a community or social, I can hardly say contagious disease and that in the interest of society we were to arrange to remove these people from our communities. For two reasons; one as a preventive measure because it is becoming pretty obvious that the development of new addicts is from a peculiar social relationship probably assisted by a great deal of emotional dependence by an immature individual on a person already addicted. Secondly, it does seem that, like many other sick people, these people have either not the will-power or the understanding to be able to go through with a course of treatment unless it is of a compulsory nature. So it does seem pretty reasonable to advocate an institutionalized approach with certainly compulsory treatment. If we go to that course, as mentioned by previous witnesses, we should provide an adequate control following discharge to allow us to follow these people and assist them before they have again slipped.

Senator HODGES: Mr. Chairman, I notice that on page 3 of the doctor's brief he says this: "The institutional treatment programs developed to date are very difficult to assess but it does not seem that they have produced any dramatic favourable results. These programs have usually been isolated from the community and this may account for the apparently low rate of successful treatment."

Other witnesses have already pointed out to us, and I believe the view has been advanced before that by keeping these addicts in institutions close to the environment in which they learned to take the drug when they come to be released you are merely returning them to the very environment which caused their addiction. You seem to hold an adverse view, doctor.

Dr. ROBERTS: I think there are two points involved here. One is the particular social area of the city in which these addicted persons frequently congregate and live. When you do not make adequate provision for them when leaving an institution they return to that environment. Another problem is when you set up a large institution with a vocational training program trying to prepare these people to fill a useful place in society, if it is situated hundreds of miles from where you can place them, it is almost impossible to set up a system of after care. This has been one of the difficult things in Lexington. They have part of the Lexington program now located in New York to try to do this, but they feel they are handicapped by being removed so far from a place in which you can really make the hospital part of the community, where you can have access to employers and so on.

Senator HODGES: Could not an institution of that type at least be located in another town?

Dr. ROBERTS: I don't think I meant to imply that it should be set up in the city where most addiction is.

Mr. LIEFF: Having in mind the number of addicts we have in this country how many such institutions do you think we would need?

Dr. ROBERTS: If we accept, as we must, at the present time that there are in the vicinity of 3,000 addicts, and if we accept that you would institutionalize them all, it would be a very large institution, much larger than, I think, most psychiatric people would be happy to see develop. On the other hand when you think of a treatment program with the vocational facilities, the counselling and guidance service that would be necessary, it would seem desirable not to have too small a facility because your cost per day per patient would be terrifically high.

Senator HODGES: You would not suggest one in every province?

Dr. ROBERTS: I do not see how, medically, you could develop adequate programs in so many institutions.

Senator BAIRD: That means this thing will remain static?

Dr. ROBERTS: It might.

Senator HOWDEN: Doctor, I also am a medical man like yourself. I was going to ask if there is at the present time a recognized specific remedy for these various individual narcotic conditions.

Dr. ROBERTS: I think, Mr. Chairman, that it is possible to withdraw the drug from addicts without too much difficulty, and once the drug is withdrawn you then have to do a basic assessment of the individual—you have to find out what his abilities are, what his weaknesses are, what are his characteristics which you can use to advantage in his training and rehabilitation. I do not think we know enough about the psychopaths in this group, and there are a lot of them—also a lot of inferior individuals—to say if we can successfully treat them all whether they happen to be addicted or not. The addiction in most of these people seems to be superimposed on an underlying makeup.

Senator HOWDEN: There is no specific plan for the individual?

Dr. ROBERTS: Each individual would have a specific plan of treatment. On admission to these institutions the patient is withdrawn from his drug and that is an individually controlled process. They have now reached the point where they do chart the degree of an individual's withdrawal symptoms, and as soon as he is over his acute withdrawal, his case is worked up with complete investigation going through from the physical, psychiatric sociological, and vocational viewpoints. At this point a conference is held and an individual program for the patient is developed. It is not an individual treatment program in the sense of specific drugs. While there are drugs that are helpful we are essentially dealing with their motivation and the way they adjust to the situation and so on. It is not specific in the drug sense but it is so in that it is designed for each individual patient.

Senator GERSHAW: What period, roughly, would be required for the withdrawal?

Dr. ROBERTS: I doubt, sir, in Lexington now that there are any patients in the withdrawal unit for more than a week. Most of them are over their acute symptoms in forty-eight hours to a week.

Senator GERSHAW: What period of time would the patient be required to remain in the institution under very strict guarding?

Dr. ROBERTS: It varies. I am speaking from memory, but my impression is that it runs an average of eight months. Again, because it is individual, you cannot generalize too much by saying that treatment should be for a stated period because some of them, if they have a good background of vocational experience and if they have not too much impairment so far as their makeup goes can return to their normal role very quickly. Others who have no education whatever when they come to you must be kept a long while to bring them to the point where they are self-supporting. I think eight months would be the average period.

Senator HODGES: Do you think, as a doctor, it would be practical to try and establish rehabilitation and treatment facilities in penitentiaries and jails and that sort of place—I mean rehabilitation of criminal addicts?

Senator BAIRD: In mental hospitals?

Senator HODGES: No, I am speaking of criminal institutions at the moment.

Dr. ROBERTS: It is my impression that this cannot be done. It is, however, out of my field. According to Dr. Gendreau, who is with the penitentiaries'

service, they are doing their best to develop a rehabilitation program for their people including drug addicts. Most people think it has to be a separate institution, that you would not be able to secure the proper environment in penitentiaries or in jails. The same problem comes up in other ways. It has been suggested on a number of occasions that some of the addicts could receive treatment in mental hospitals. It is apparent that an addict, who has received treatment in a mental hospital, requires much more restraint than the ordinary mentally ill patient. So it appears that there would have to be an institution for this specific purpose, with the exception of the group of mentally ill who have the same underlying make-up; I am thinking of the psychopathic patients. There are a group of mental people who are similar to these, except they are not addicted.

Senator HODGES: I wish to ask you, doctor, a question I have asked other witnesses. Do you think that the suggested clinics for the free distribution of drugs would help in the matter at all?

Dr. ROBERTS: No.

Senator HODGES: You do not?

Dr. ROBERTS: I cannot see this. That is my personal opinion.

Senator HODGES: I ask for your personal opinion.

Dr. ROBERTS: I cannot see it as treatment. It seems to me that we have here a group of people who for social or psychological reasons have become acquainted with these drugs and have started to take them, and finally, even while they take them, they are not well at all. The addict when he is getting his drug is trying to feel good; he feels terrible when he has not got it; but even if you give it to him, while he feels relatively good, he is always worried—will he get his next dose in time? And it seems to me the real treatment for these people is to get at the underlying psychiatric and social conditions that exist. I cannot see that merely giving them the drugs would do very much.

Senator BAIRD: Do you not think that the "pushers", the people forcing the sale of this thing, are an important factor? In other words, they entice people to use the drug, and to my mind the pressure is brought about by the profit that is behind this business.

Dr. ROBERTS: I think when you read Dr. Stevenson's report and you hear him, you will find one of the hardest things to do in working with this group is to find a new addict. This seems to be a contradiction, because somebody has already hinted this afternoon that if no new ones are being created, you only have to wait until they all die off. They must come from somewhere, through association perhaps, but in visiting these areas and talking with addicts and the police, we do not find any evidence that the "pusher" is "pushing". On the contrary, it seems to be extremely hard for a new person to get drugs, and there is no evidence of anyone trying to sell drugs to new groups all the time.

Senator BAIRD: But you showed it on your own film.

Dr. ROBERTS: In that case, the kid was already frequenting these areas and associating with this group, and wants to know what it is like.

Senator HODGES: You don't call that "pushing".

Dr. ROBERTS: That is curiosity. We have talked to a number of these people, and rather got the impression that a good many addicts may try to keep new ones from getting it.

Senator HODGES: That is certainly contradictory to some of the reports we have heard from the Coast. It is interesting to hear that point of view.

Mr. LIEFF: With respect to the 333 professional addicts, how would you go about treating them?

Dr. ROBERTS: Medically, I feel that all addicted persons should be treated.

Senator BAIRD: Should be forced to take treatment?

Dr. ROBERTS: Well, if necessary, should be forced. They should be treated.

Senator BAIRD: They would not all be voluntary: you made that statement.

Dr. ROBERTS: That is right.

Mr. LIEFF: These, of course, are nurses, doctors and dentists we are talking about.

Dr. ROBERTS: Certainly, with their professional background, they should do well. Professional people treated at Lexington do better than the average. People with a good vocational background are better prospects than those who have nothing to start with.

Senator BAIRD: Still, they are worse prospects when they start.

Dr. ROBERTS: In some ways. They know too much.

Mr. LIEFF: We have been talking about quick withdrawal. Do you know whether quick withdrawal leaves any harmful effects,—physical effects?

Dr. ROBERTS: Well, certainly, withdrawal from the opiates—quick withdrawal—leaves no harmful physical effects. This has been studied at great length. There is considerable argument in connection with the treatment as to whether the so-called “cold turkey”, which means immediate withdrawal, has a psychological effect on the patient which impedes adequate treatment. Some of the people involved in Lexington say “You must give them sufficient drugs to ease their withdrawal period.” But right on their own staff they have people who say “We don’t see any difference.”

Senator HODGES: If an addict goes to jail, is that a quick withdrawal?

Dr. ROBERTS: That is my impression. Across the country it is probably “cold turkey”—immediate withdrawal.

Mr. LIEFF: Has anybody died from that sort of thing?

Dr. ROBERTS: I don’t know of any deaths that have been reported. A few have been reported in the States, but these deaths are from combined opiate and nembutal addiction. Nembutal is much more dangerous than opiate withdrawal. No deaths have been shown as due to opiate.

The CHAIRMAN: Is the alcoholic as great a menace to the general welfare as the drug addict?

Dr. ROBERTS: This is put forward by certain people: when the addict is at his so-called maintenance level he does not appear to be a seriously dangerous person to himself or to others. He is a pretty good person when he is at his maintenance level.

Senator HODGES: What do you mean by “maintenance level”?

Dr. ROBERTS: I say “maintenance level” though I am not sure what anyone means by it. The inference regarding maintenance level is that these people can get by on a regular dose.

Senator QUINN: Enough to satisfy him?

Dr. ROBERTS: Yes. A person taking intoxicating drugs, including alcohol, is liable to become confused, and therefore accidents are prone to occur. To say one is more of a menace than the other . . .

The CHAIRMAN: Any other questions? . . . Doctor, may I on behalf of the Committee thank you very sincerely for your talk to us.

The Committee adjourned.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

EVIDENCE

OTTAWA, WEDNESDAY, March 30, 1955.

The Special Committee on the narcotic drug traffic met this day at 10.30 a.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable senators, we now have a quorum so will you please come to order. It is unfortunate that there are so many Senate committee meetings being held at the same time but this seems to be inevitable. We have as our main witness this morning the chief constable of Vancouver, British Columbia, W. H. Mulligan. He will present a brief to the meeting. I have great pleasure in asking Chief Walter Mulligan to come forward.

Mr. LIEFF: Mr. Chairman, for the record may I say that I have just had an opportunity of having a few words with Mr. Mulligan, whom I have found to be very modest. However, he did tell me that for twenty-eight years he has been with the Vancouver police force, and for eight years he has been the chief constable. I understand that he is the immediate past president of the Association of Police Chiefs.

Mr. MULLIGAN: Mr. Chairman and honourable senators: In presenting to you details of the problem of narcotic drug addiction as it is encountered by the municipal police of the City of Vancouver, I would like first of all to express the gratitude and appreciation which we at the Pacific Coast feel in the knowledge that our government has taken action to seek ways and means of meeting this increasingly serious problem by setting up this Committee to inquire into all aspects of it. I feel I am speaking not only for the police authorities, but also for all the citizens of Vancouver when I express to you, Mr. Chairman, our appreciation of the keen personal interest which you have taken in this subject.

In outlining to you details of the drug problem as it is encountered by the municipal police in Vancouver, I propose to deal with the subject within the period of my own police service, describing the activities of the police in meeting the problem; the efforts of the community over the years by representative citizen groups taking an active interest and setting up committees at different times in an endeavour to assist the authorities in finding a solution; outlining the method of distribution from the time the drug reaches the city until it gets into the hands of the addict; telling you what we know about the addict himself, and what we have learned about him by meeting him face to face under many and varied conditions. Finally, for what it is worth, I will relate to you the thinking of the police officer as regards a possible solution of the problem.

First, I have with me a list of persons who have been charged under the Opium and Narcotic Drug Act in Vancouver. These persons are listed alphabetically, showing their criminal record number and the number of times they have been convicted under the Drug Act. This list, revised up to February 1, 1955, totals 1,158 persons.

I also have with me a list of persons in Vancouver suspected of being drug addicts. This list is also made up alphabetically and gives the suspect's criminal record number where such record exists. A suspect for the purpose of this list is a person who has been checked by the police on suspicion of

being an addict, that is to say, he has been frequently seen and questioned by the police when in company of convicted addicts. In many instances the suspect would show visible signs of addiction in the form of needle marks on his arms, but lacking sufficient evidence (actual possession of drugs) on which to base a charge, the police note his name on the suspect list. This list totals 423 persons.

For the information of your Committee, I am including as an appendix to my brief, statistics giving a break-down of arrests and convictions under the Opium and Narcotic Drug Act in Vancouver during the period 1941 to 1954. (See Appendix F).

At the end of this month I will have completed 28 years service with the Vancouver City Police Force, and thinking in terms of the present drug problem, and speaking to other senior officers of the Force, it is our recollection, in the absence of accurate records, that at the time I commenced my police service in 1927, the number of known addicts in Vancouver did not exceed 200, and the total number of peddlers or traffickers was less than 10.

In the late 1920's, the Vancouver Police Department maintained a narcotic squad. While it consisted of only four men, their work was fairly effective, and, of course, they closely co-operated with the Royal Canadian Mounted Police. Shortly after a major police investigation in 1929, the squad was disbanded, which accounts in part for the lack of accurate statistics for a period of time leading up to the commencement of the second world war.

About the end of 1939, a detail of men in the Detective Division of the Vancouver Police was set up to cover hotels and rooming houses, their main task being to locate and keep daily check on active criminals for the information of the Force. As a result of their activities, they frequently came across addicts in rooming houses in possession of drug paraphernalia, and many times came upon them in the act of self-administration of drugs. These activities gradually brought the municipal police back in the field of narcotic work, and it seemed that within a short period of time members of the Vancouver Police were actively engaged in securing evidence on which to base charges for possession of drugs, leaving the Royal Canadian Mounted Police Drug Detail freer to concentrate on the major problem of the peddler or trafficker, and those persons responsible for bringing such drugs into the city.

Certain officers developed an aptitude and great interest in this work, and we have in our department several men who have worked unceasingly day after day for many years now in the fight against the narcotic drug problem. When your Committee visits Vancouver, I would like to arrange for you to interview some of these detectives, for I know they could give you some very practical and factual information.

Originally, the drug problem as it was encountered in Vancouver concerned opium smoking and the illicit use of cocaine. Over the years the pattern changed, and in the early part of World War II we found codeine and benzedrine appearing on the scene and being used. As the war continued, an acute shortage of narcotic drugs developed, with the result there was a tremendous increase in the use of barbiturates such as nembutal, seconal and luminal. The barbiturates, of course, are not listed under the Opium and Narcotic Drug Act.

About 1945, the police became aware that addicts were using, in increasing quantities, the drug diacetyl-morphine hydrochloride, a white powder commonly known as heroin. Today, with practically no exception, this is the drug which is creating an ever increasing number of narcotic addicts in Vancouver, and it is the opium derivative with the strongest habit forming characteristics, and is the most insidious of the illicit narcotics.

It has brought into existence syndicates of drug peddlers whose spectacular efforts to gain control of this most lucrative, illegal activity have in the space of recent months resulted in one murder, two attempted murders, and three cases of aggravated assault in the city of Vancouver. We are witnessing in Vancouver today, an ever increasing degree of organized crime. It is possibly part of one of the most advanced and highly organized criminal organizations to be found anywhere, and on a national scale in Canada involves millions of dollars.

The first survey of the drug traffic in Vancouver that I am familiar with was that made by the Royal Canadian Mounted Police in 1945, and their survey showed the average age when drug addicts were first arrested was 21·8 years. They started on drugs at an average of 21·9 years. The survey also showed that 54·5 per cent of these addicts started using drugs at an average age of 17·4 years—juveniles even then. A national estimate of drug addicts in Canada in 1948 showed 4,000 criminal addicts in this country.

In July 1951, the Social Services Committee of the Vancouver City Council requested the Chief Constable to submit a report respecting the illegal use of narcotics in the city, and I would like to quote a paragraph from the Chief Constable's report:

During the period from January 1, 1951 to July 11, 1951, there have been 124 persons charged under the Opium and Narcotic Drug Act and brought before the Vancouver City Magistrates Court. Of this number, 84 were arrested by members of the Vancouver City Police and the balance—40, were arrested by officers of the R.C.M. Police. The ages of the total persons arrested are summarized in the following grouping:

Under 20 years, 3 (all 19 years old); 20 to 29 years, 62; 30 to 39 years, 28; 40 to 49 years, 14; 50 to 59 years, 12; over 60 years, 5.

Senator HOWDEN: Why do you suppose the number declines after the age of twenty-nine? Is it through death?

Senator QUINN: That is the age at which they were arrested.

Mr. MULLIGAN: Yes, that is correct.

Senator HOWDEN: I understand that, but that is the age at which the number drops. Would that be because they have lived their span of life?

Mr. MULLIGAN: I would say, sir, that the health of these people is not good, and they are victims of sudden death.

Senator QUINN: They do not endure.

Mr. MULLIGAN: No; they are what we call potential certain death.

Senator HOWDEN: I just wanted to hear your comment on that point—thank you.

Mr. MULLIGAN: The first prosecution of a juvenile, that of a boy aged 14 years, on a drug charge in Vancouver was in 1950, but it is undeniable that the age of citizens forming the drug habit is steadily moving into the lower age brackets.

The Chief Constable's report to the City Council, of course, covered briefly the whole drug problem as it affected the Police Department. At a City Council meeting on August 14, 1951, the Chief Constable's report was read and the City Council recommended that it be referred to the Police Commission with the request that the Commission take immediate steps to rectify the situation, and that if it was felt the City Council could in some way co-operate, advice to that effect would be appreciated.

On August 24, 1951, the Board of Police Commissioners instructed me to confer with the Officer Commanding, Royal Canadian Mounted Police in Vancouver to see if between us we could not increase the strength of our respective

drug squads and make a more determined effort to stamp out this serious situation. I met with Superintendent George Archer of the R.C.M.P., and surveying our commitments in other problems and in the light of the information we had just received regarding the forthcoming Royal visit, we had to decide to continue our present efforts with the number of men already assigned to that work, and that immediately after the Royal visit, we would work together and attack this problem with vigour.

In November, 1951, a meeting was held at the City Hall, called by the Mayor, at which representatives from the medical, legal and teaching professions, and from the Community Chest, freely discussed the problems of narcotic addiction, and listened to the former Attorney-General, Mr. Gordon Wismer, express his views on the matter.

At this time plans were being made by the two police forces, and they were designed to catch the traffickers, and here I would like to pay tribute to the great deal of undercover work which was carried out by members of the Royal Canadian Mounted Police and which, of course, required considerable time. During the winter months of 1951, a situation in the illicit drug traffic arose wherein a shortage was created by these traffickers in order to raise the price of drugs. When I tell you that a great deal of our major crime, conservatively estimated by myself and my senior officers to be 60 per cent, can be traced to narcotic addicts, you will appreciate that this shortage was soon reflected in an upward surge in thefts and burglaries in the city. It is not a comforting feeling for a Chief of Police to watch crime surge upwards rapidly and at the same time be patient enough to supervise the efforts and work of police officers who are painstakingly gathering evidence on which to base prosecutions. On January 17, 1952, the two forces joined together in rounding up peddlers and addicts. In two days, 22 men and 5 women were arrested; 3 women and 13 men being charged with selling drugs, and 2 women and 9 men charged with drugs in possession.

The publicity arising from the January prosecutions brought the narcotic problem very much to the fore again, and in May, 1952, a representative group of Vancouver citizens was invited to act on a committee under the sponsorship of the Community Chest and Council of Greater Vancouver to study the problem of drug addiction in Canada and its solution. This committee, under the Chairmanship of Dr. Lawrence E. Ranta, prepared a report which was published in July, 1952.

Following the publication of the Ranta report, the Community Chest and Council set up a standing committee under the chairmanship of Dr. A. R. Lord, and the terms of reference for the committee was given by the Board of Directors of the Community Chest and Council when it accepted the Ranta report were to the effect that this committee move towards the implementation of the recommendations contained in the report by all means that shall appear to be in the best public interest.

During this same period of time, members of the Vancouver Police assigned to enforcement of the Narcotic Drug Act began an investigation in connection with the alleged peddling of drugs to high school students in the vicinity of the school itself. Fortunately we found the information was unfounded. What had happened was that a high school student, a juvenile girl, not having to write examinations, was permitted to leave school some weeks before the commencement of the summer holidays. This girl secured a position as a waitress in a cafe where she came into contact with some addicts and started to use drugs. The joint investigation by the Vancouver City Police and the Royal Canadian Mounted Police resulted in 7 persons: 6 men and one woman; being charged under the Opium and Narcotic Drug Act for having furnished drugs to several juveniles. These persons were convicted and received sentences ranging from 5 to 7 years with fines up to \$1,000. In addition, the 6 men were ordered to be whipped.

Continuing on from 1952 up to the present time, there has been steady, relentless pressure on the part of the two police forces fighting the drug problem, and the statistical report of arrests over the years contained in the appendix shows this. At the same time there have been some spectacular prosecutions against traffickers resulting in long prison terms being meted out. It is unfortunate, however, that in spite of this sustained effort of the two police forces, the situation has been steadily deteriorating as the number of addicts has increased and the traffickers have formed syndicates, and are always planning new and ingenious methods for the illegal distribution of drugs.

I am informed by our drug detail officers that as far as can be learned, most of the heroin that reaches the illicit market in Vancouver originates in Mexico, from whence it is shipped to the Eastern United States, and then to Eastern Canada to such cities as Montreal, Toronto and Hamilton. Some of it comes from the Eastern Mediterranean, and some also comes from Red China by way of Hong Kong. A small amount reaches Vancouver direct from the Orient by ship. Heroin is bought in Eastern Canada at prices ranging from \$500 to \$600 per "piece" or ounce, and it is known that sometimes as much as 30 ounces is purchased at one time. The heroin is then brought to Vancouver in many ways, using automobiles, trains, planes and by mail. The containers or parcels are usually camouflaged, or brought in by some person unknown to the police. Despite the fact personal baggage of travellers in Canada is not subject to inspection as is the case when entering or leaving another country, the traffickers nevertheless go to great lengths in camouflaging the shipment of drugs. There are numerous ways, depending on the ingenuity of the distributor. Drugs are often sent through the mail in small parcels in a talcum powder tin, or hidden in other types of cosmetics; it may be in rubber containers in the gas tank of a car; it may be secreted in the false bottom of a suitcase or other type of baggage.

On arrival in Vancouver, the drug is turned over by the distributor to an associate whose job usually is to pack it in capsules and then "plant" it or hide it in certain locations throughout the city, giving the locations to the distributor. When the associate, known as the "plant" man, starts to place the heroin capsules, he will have a supply of sugar or milk, a white powdery substance that resembles heroin. He will mix up one ounce of sugar or milk with one ounce of heroin, thus adulterating the drug to make up two ounces of mixture. A supply of No. 5 clear gelatin capsules, obtainable legally at any drug store, would be on hand, into which he would cap up the mixture. One ounce of the powder makes or fills 400 capsules, more or less, so from the original ounce of heroin, 800 capsules of adulterated heroin are obtained. The next procedure of the "plant" man is to pack five of these capsules into a small rubber balloon, the ordinary toy balloon which can be bought by the gross in any novelty store, tying the end of each balloon with a slip knot. This man will then put 10 or 20 of these balloons into a rubber condom and tie the end of the condom with a slip knot. His next procedure will be to "plant" or conceal these bundles around the city in different locations and at definite markers; the marker usually being a telephone pole, fire hydrant, stop sign, street sign post, the corner of a garage, or even a clothes line post. I recall one case in Vancouver where a cache of drugs was seized and an arrest made where the particular marker used was a seat or bench set up on the sidewalk for the convenience of passengers waiting to board street cars. The street address of premises adjacent to the marker is then written down, usually in code form, and turned over to the distributor. The stage is now set for the next step in the distribution procedure. The distributor first mentioned is now contacted by the "peddlers" or "pushers" for their supply to sell on the street. The distributor usually charges, that is, in Vancouver, \$2.00 a capsule to the street peddler or pusher. Therefore, the original

ounce of heroin bought for \$600, and made up into 800 capsules of adulterated heroin brings the distributor \$1,600.00, making him a profit of \$1,000.00. If 30 ounces had been handled by this distributor at one time, his profit would have been \$30,000.00, and it is known by the police that in some instances the heroin is adulterated to an even greater degree by the distributor than in the example I have just quoted.

The plant man who does the original capping up, generally uses a different location each time to do this work. Popular places are auto courts or motels where there is an inside private toilet into which he can flush the drugs in the event of being surprised by the police.

Referring again to the street peddler or pusher, when he has contacted the distributor, he will pay over the money first and in return is given the location of one of the "plants". He will go there immediately, search and recover the hidden drugs. Very often the street peddler will go to some safe place himself and still further dilute the heroin. As an illustration, if the street peddler buys 50 capsules, he would dilute it, again using sugar of milk, and make 100 capsules from the original 50. This peddler has paid the distributor \$100.00 for his 50 capsules, and he now has 100 capsules of doubly adulterated heroin. This man then sells to the addict on the street at \$4.00 per capsule, realizing \$400.00 and making a profit of \$300.00.

The method used by the street peddler is to put 10 or 20 capsules in a rubber container, place this small bundle in his mouth, and proceed to a beer parlour, cafe, pool room or coffee shop and await the drug seeking addicts. Sometimes a street peddler will use a man known as a "steerer", who will walk around the vicinity where addicts congregate, telling of the location of the peddler to any addicts that he meets. When a street peddler proceeds to a location such as I have mentioned, he is very careful to find a seat facing the entrance and usually sits with his back against a wall. The drugs are in his mouth and he will swallow them immediately should he see a police officer entering the premises. Should it be necessary for the peddler to swallow the drugs, and it often is, these people are adept at regurgitating them, and, being in a water-tight rubber container, the drugs are recovered undamaged.

When the addict himself contacts the street peddler, he pays over his four dollars and receives his capsule in return. The peddler may even take the drug out of his mouth seated where he is and pass the drug to the addict. Generally, however, he will go to a toilet and lock himself in one of the cubicles, and then extract from his package the number of capsules required. In this way he protects himself from the police, for should the police endeavour to catch him at this point by breaking into the cubicle, the peddler will immediately flush the drugs down the toilet and the police would be compelled to release him for lack of evidence.

When the addict has obtained his capsules from the street peddler, he immediately wraps them in silver paper, and places them in his mouth so that he can swallow them if checked by a police officer. And, of course, like the peddler, he can recover them intact after the officer leaves. The addict will then proceed to his room, usually located in one of the cheaper hotels or rooming houses, and will first look around to make sure no police officer is awaiting him. After he has checked his room, he will then pick up his paraphernalia for using the drug. This is rarely kept in the room, but is usually hidden in an adjacent hallway, bathroom or toilet. On returning to his room, he will lock and bolt the door, and even barricade the door with a chair. Sometimes he will wait a short period after this step in the event that he has been followed by the police, who might break down the door in an effort to catch him with incriminating evidence in his possession. On satisfying

himself that the coast is clear, the addict then prepares to take his injection of drugs. It usually takes from five to ten minutes to prepare and clean up afterwards. The paraphernalia used consists of an ordinary teaspoon, a hypodermic needle, obtainable at any drug store, a few drops of water and matches.

I am sure you will have noticed from the account I have just given you, the extreme precautions taken by the peddlers and addicts to avoid being caught by the police in possession of drugs. When one considers the number of addicts as compared with the small number of police officers assigned to enforcement of the Drug Act, I think this speaks well for the work of the police, and also emphasizes the dread fear of the addict of being cut off from his soul destroying habit by reason of imprisonment.

The method of distribution I have outlined to you has been in use in Vancouver for a number of years, and addicts, both male and female, congregate in one East End locality particularly, and for a period of time a number of them favoured an up-town location. The majority, however, used the East End location and they favoured certain beer parlours and cafes. There was an advantage to the police in this because a smaller number of officers was able to keep this area under fairly constant surveillance. However, times and methods change, and a year or so ago the street peddlers in Vancouver changed their system of peddling drugs on the street and have now gone what might be termed "mobile", by receiving orders over the phone and making delivery by automobile in the following manner.

Instead of the street peddler working on foot alone as formerly, several have joined forces and we know of occasions when as many as five of them would be operating together at one time. The addict wanting to buy drugs phones a certain number and the peddler taking the order will instruct the addict to wait on the corner of two intersecting streets, usually well away from the down-town area of the city and in a district where there is the smallest concentration of police. The peddler has one or two men driving around in an automobile. They have the drugs with them and they will phone in to the peddler on the average every half hour and receive from him the location where the addicts are waiting. It is very rare that drugs are secreted anywhere near the telephones used for phoning in. Upon the receipt of a location, the men in the car drive there and pick up the addict almost without stopping the car. They drive the addict around whilst the transaction is taking place, then let him out quickly and drive on to make another contact. This type of peddler usually sells at a "wholesale" price, that is, 5 capsules in a balloon for \$15.00, or sometimes 3 capsules for \$10.00. Seldom does he sell only one capsule at a time for \$4.00. This method I might say makes it very difficult for the police to catch the peddler selling drugs to an addict for the simple reason the peddler keeps the windows and car doors locked and he will calmly swallow the rubber balloon of capsules while the police are trying to break the windows and get into the car to seize the drugs before they disappear in front of their eyes. It is almost impossible for officers in a police car to follow and surprise the peddlers, for they keep a sharp lookout, becoming very suspicious if a car following them makes even two changes of direction to coincide with their own. As a result of the police obtaining the telephone numbers of peddlers from "informers" and so tracing their location, this type of peddler is becoming even more cautious by having only one man who knows the telephone number circulating amongst the addicts. This man phones orders in himself and in turn notifies the addict where to make contact.

Authorities on the subject state that it only takes from two weeks to a month for a person to become addicted to drugs. A person on first becoming addicted can get along with only one "fix" a day, using one-eighth grain, but as time goes by he will find that not only does he need a larger dose of drugs

but that he needs it more and more often until he becomes an average addict and is using one capsule to a "fix" four times a day. I have heard of addicts using as many as 12 capsules a day, which would probably consist of four "fixes", each of 3 capsules.

Assuming the addict buys the drugs at the "wholesale" rate of \$3.00 per capsule, he will need at least \$12.00 per day for drugs. The criminal addict, in order to obtain \$12.00 cash, must steal it, or obtain by some other illegal means at least \$36.00 worth of goods, as stolen goods will only bring about one-third of their actual value when disposed of through the "fence" or receiver of stolen goods.

Addicts turn to all types of crime to obtain money for drugs; theft, particularly shoplifting and prowling hotels and rooming houses; burglary; forgery; prostitution; strong-arming of drunken citizens; and holdups.

I have mentioned the figure of 1,158 criminal addicts in Vancouver. For purpose of illustration, let us take the figures of 1,000 as being the average number of such criminal addicts roaming the streets of Vancouver. I use the word average again to imply that these addicts need the average dosage of 4 capsules a day to satisfy their craving. At \$12.00 per day each, this means \$12,000.00 per day cash to keep them all supplied, or a monthly average total of \$360,000. To supply these 1,000 addicts with their daily dosage for one year would cost \$4,320,000.00. There is only one way for them to obtain this money, and a conservative estimate of the equivalent cost in crime would be \$10,000,000. I remind you, these figures are conservatively estimated.

I am sure you will appreciate the impossible task confronting the police. Not only do we have to try and cope with the problem of the distribution and sale of drugs, but we also have to cope with the crime committed by addicts in their efforts to obtain the money to finance their habit.

Now, what about the increase in the addict population? The Vancouver Police compiled a list of persons charged under the Opium and Narcotic Drug Act in Vancouver on December 2, 1952, and it totalled 915 persons. A list of suspected drug addicts compiled at the same time totalled 416, making a combined total of 1,331. On February 1, 1955 I had an up-to-date list compiled for the information of your Committee, and the number of convicted persons had increased to 1,158, and the list of suspected drug addicts to 423, making a combined total of 1,581. In other words, a total increase of 250 in two years and two months. Speaking conservatively, I would say that the addict population in Vancouver increases by 10 each month.

What sort of person is our drug addict? Some authorities will tell you that drug addicts are nice people, but it is the police experience that this is far from being the case. We find that an addict does not care about his parents, his wife or children if any, his best friend, his health, his cleanliness, nor his clothing and personal appearance. He does not care about society, nor does he lead a useful existence. He does not drink intoxicating liquor, and he does not get along well with others unless, of course, he is under the influence of narcotics. He does not work, in fact will not work unless he is forced to do so to prevent being arrested for vagrancy. When an addict is under the influence of drugs, his sense of well being is such that work does not interest him in any way, and then when he needs drugs, his physical condition is such that his craving for drugs makes it impossible for him to concentrate for any length of time on any task, no matter how light or menial. The drug addict has no morals, no principles, and very seldom tells the truth. He usually has poor health, particularly if he has been using drugs for any length of time without having been to jail.

I have seen in our police courts, time and time again, drug addicts being sentenced and their appearance indicates poor health, pallor, nervousness and malnutrition, and I have seen the same people repeatedly upon their release

from prison looking greatly improved in health and appearance, only to observe them within the space of two or three weeks declining physically, at least as far as their general appearance would indicate. I would emphasize that these assertions are based upon my own personal observations over a period of many years.

In the majority of cases the addict has a long criminal record, many of them a record of incorrigibility as a juvenile before they became addicted to drugs. Addicts have come from broken homes, homes where parental influence and responsibility did not exist.

How does the average addict become addicted to the use of drugs? They get started in many and varied ways. Young girls and women often meet men addicts who get them started on drugs so that they can turn them into prostitutes and thus obtain money for drugs. Some men have more than one girl working for them at one time. Men who have been engaged in criminal activities will come into contact with confirmed addicts in underworld hangouts, and from this association, will become addicts themselves. They will often live with a woman prostitute addict and acquire the habit from her. In the past, the street peddler or "pusher" would be responsible for some persons becoming addicted, although our experience today is that the "pusher" will not sell to anyone but a known addict, fearing detection by the police. However, the chief way that addicts get started is by associating with confirmed addicts. They see the confirmed addict taking injections of drugs as they associate together in rooming houses; they hear the addict talk about practically nothing else but drugs. They get used to the idea, they get curious, and then are often persuaded to start. Beginners usually think they can take an injection of drugs once in a while and not become deeply addicted, only to find out very quickly, and too late, of course, that they have become addicted. One aspect of this situation which causes a great deal of worry to police officials is the growing tendency on the part of many irresponsible teen-agers, having heard a great deal about drugs and seeking a new thrill, allowing themselves to be persuaded to take a "fix". Detectives on our Drug Detail inform me that under favourable conditions, a teen-ager being able to get into rooming houses in the company of addicts without detection by the police can become deeply addicted to drugs, and I am referring to heroin, in the period of from two weeks to one month.

I understand your Committee will have every opportunity when in Vancouver to enquire into the records of the lives of certain of our criminal drug addicts, and will be able to obtain at first hand much of the information I could give you. In dealing with this phase, I will therefore confine myself to quoting from the records of five of the many criminal addicts personally known to me. The first two are men both now 50 years of age, whom I have arrested on occasion and have known personally for over 20 years. The other three, now in their thirties, I have known personally since they were young lads.

I have the records with me, Mr. Chairman, which I will give you.

No. 1—Case "A".—First arrested for drugs in January, 1938, two charges. Has led a persistent life of crime through shoplifting, and in the past 20 years his time has been divided between prison and freedom. This man could no doubt be interviewed by your Committee.

No. 2—Case "B".—I first knew this man in 1930. Smartly dressed and of good appearance, he was very adept in prowling hotel rooms and stealing money and valuables from the clothing of sleeping guests. Similar to "A", this man has spent all his adult life between Oakalla Jail, the B.C. Penitentiary and freedom in the city of Vancouver. He is progressively deteriorating, and in recent years has lost his former skill as a thief, resulting in him being detected and arrested more frequently. A year ago he pleaded with me for help to get him a job as a waiter in the dining room of a northern construction camp . . .

I spoke to the personnel manager of a large company, told him of the man's background, warned him of the risks that might be encountered and then asked if he would give him a trial. Two days later this criminal addict came to see me, and he seemed quite proud of the fact that for the first time in his life he had an unemployment insurance book. The man was doomed to failure however. In order to work in the kitchen, a medical examination was required and this he could not pass. My negotiations on his behalf had been conducted in light of the fact he had just been sentenced to 6 months imprisonment for vagrancy, the magistrate ordering the warrant withheld for 48 hours to give him a chance to leave Vancouver. As it was impossible for this man to exist away from the City, and as he had no funds to travel elsewhere, he was soon picked up and went to serve his sentence. With the exception of very short periods of time, a matter of weeks at the most, my personal knowledge of this man is that he has never done legitimate work but has led a life of crime for 25 years.

No. 3—Case "C"—Here is a man now 34 years of age. I first met him when he was 16 years old. As a detective I had arrested this boy on a burglary charge. Although he went on probation, one conviction followed another until 1938, when he was no longer treated as a juvenile but transferred to the ordinary court. He was involved in a murder case, and charged with murder, just before his eighteenth birthday. He was sentenced to be executed, but in a new trial ordered by the Court of Appeal, he was found not guilty. About this time he met a woman prostitute, a drug addict, and went to live with her and became addicted to drugs. His record since has been one of charges of burglary and possession of drugs. He was convicted on February 4th this year and sentenced to 3 years, for possession of drugs. I have never known this young man to do an honest day's work since I met him 18 years ago.

No. 4—Case "D"—This man is also now 34 years of age. As a detective, I arrested him in December 1937 when he was 16 on three charges of burglary. He was transferred to the Juvenile Court and then returned for trial to the Police Court because of his bad juvenile record. He was sentenced to two years in the penitentiary, the youngest inmate to be admitted to that institution up to that time. He continued his criminal career, and his first charge under the Drug Act was in 1946. In 1951 he was charged with selling drugs, and in a County Court trial was found not guilty. The Crown appealed, and the Court of Appeal found him guilty and he was remitted to County Court for sentence and received six years plus \$1,000.00 fine or one year additional imprisonment. This young man also persisted in a life of crime, and has been a drug addict for many years.

No. 5—Case "E"—This man is 30 years of age now. I arrested him for theft when he was 13 years of age. He maintained a persistently bad juvenile record, and as an adult, his criminal record extends from 1944 up to the present day. He was first arrested under the Drug Act in 1945. He is an accomplished room prowler and only two weeks ago was surprised in a Vancouver hotel and in an attempt to elude the hotel detectives, he stabbed the detective with a knife and has been charged with wounding.

These three young men I know particularly well. I have talked to them many times on the street. In conversation with this last case, he has often reminded me of the times I had taken him to the Juvenile Detention Home, and says he wished he had listened to me with more attention. He told me one day recently "When my mother made excuses for me I thought it was smart that I was fooling the cops, but I know now that I was only fooling myself". He tells me it is too late now to do anything, and he is only 30 years of age.

I would like to make mention of one more case, although this man is not known to me personally. We will call him Case "F". This man, born in 1929, was involved with two others in the murder of two policemen in January, 1947, in the city of Vancouver. He was then 17 years of age. He was sentenced to be hanged, and then a re-trial was ordered and he was found not guilty in 1948. Now, one would think that the ordeal of a murder trial on one so young would have had the effect of turning him away from a life of crime, because he had not previously been involved with the police. But what do we find? Two years later he was charged with possession of drugs and was again fortunate enough to be found not guilty. On October 14, 1953, he was again arrested under the Drug Act and sentenced to two years.

Mr. Chairman, I could go on listing cases for hours, but the point I want to make is that we have this problem, and what is to be done about it? I wish to make it clear that the police have no issue to raise with the thoughts and ideas of the medical authorities, sociologists, criminologists and other well-meaning people. Any constructive ideas or suggestions they may put forward towards meeting the problem in which the police could play a part, we would be the first to welcome them. It has been emphasized that drug addicts are a medical problem. We, in the police service, have no quarrel with that, and can agree, but we would like to pose these questions to the medical people. Is there a permanent cure known to them? Can they tell of a rehabilitated drug addict? I would stress here that I am speaking of the heroin addict.

It has been suggested that addicts be registered and then given free drugs at clinics, and this has been put forward by some well-meaning people as a solution. I think it was said that minimum doses could be given at these clinics, that is, sufficient to keep the addict happy. If minimum doses were given at such clinics, addicts would, of course, attend and get this dose, but they would then go on and buy more drugs on the illicit market to get the quantity they crave so much. Suppose the clinic staff increased the dosage to make it unnecessary for the addict to buy on the street? I can foresee a great deal of difficulty arising from such a practice. Addicts would all be trying to live as near the clinic as possible, and I am sure clinics would be necessary in every centre of population throughout the country, for if there was only one clinic in say the two main cities facing this drug problem, addicts would flock to these cities from all over Canada and even the United States.

Heroin destroys the body physically and mentally, and it does not seem right to me that the country should provide these people free a drug which has such devastating effects. Even if the addict were given free drugs, what about his criminal tendencies? I am sure they would be involved in crime just the same as they were before. It also seems to me that other criminals and persons with criminal tendencies who are not addicts now would probably become so if they thought they would not have to go to jail if they used drugs.

What would be the attitude of the drug trafficker and the large distributor of illicit drugs if free clinics came into being? It is possible they would flood the illicit market with very cheap drugs and so put the purchasing of drugs within the means of adolescent boys and girls who would not worry about becoming addicted if they were later going to receive free drugs from a government clinic. Frankly, the police do not feel that you are going to be able to rehabilitate addicts in any way by giving them free drugs; and one final point about clinics, it must be remembered that they would have to be open continuously 24 hours a day, because addicts need drugs about every five or six hours.

I am aware of the work that is being done in connection with addiction in some of the large cities in the United States. For example, Bellevue Hospital in New York City, where they have treated addicts, and in Lexington, where they have a large treatment centre for addicts who go there from various parts of the country for a cure. I have been informed that the results have not been very encouraging.

I do not have much information concerning the drug situation in England, but I do believe that the addicts in England all use morphine and not heroin. I would emphasize again that heroin addiction is far more dangerous. I have been told that of the 300 addicts believed to be in England, over 100 are doctors and that the balance are in the middle or upper classes of society, which is certainly not the situation here in Canada.

Returning to our own problem, and particularly mine, why do drug addicts come to Vancouver in large numbers, and why do we have so many? Many, of course, belong, having been born and raised in the city, but I would point out that drug addicts like a warm climate and as Vancouver seems to be favoured more in this respect than many other Canadian cities, many of them go there. They also like the company of their own kind, and when they do arrive and find the company of other addicts, they stay and in turn attract more and more addicts. To these reasons for the large number of addicts in Vancouver, we must add the other attraction that drugs are cheaper in Vancouver than anywhere else in Canada, being \$4.00 a capsule, or \$3.00 a capsule if bought in quantities of five or more. As far as I can ascertain, a capsule is worth \$15.00 in Calgary or Edmonton, around \$10.00 or \$12.00 in Winnipeg and \$6.00 a capsule in Toronto.

The large number of addicts in Vancouver provides a ready market for the distributor of drugs, who can then import drugs into Vancouver in large quantities. Buying large quantities, the distributor can get the drugs cheaper and thus sell them cheaper. The large market available means big money, and attracts more and more distributors who form syndicates, as already mentioned, for the purpose of doing business.

Discussions of this problem bring out a great deal of comment, even in newspaper items, that we must stop the peddlers—catch the traffickers, and I can assure you the police are in full agreement. Years ago we realized this and asked for more severe penalties. However, it must be realized that if we were capable of arresting all the big traffickers at one time, it would not stop the selling of drugs, because whole traffickers were out on bail awaiting trial, they would have lots of time to re-organize their drug rings before their trial took place.

I have been dealing with local conditions in Vancouver, and I would again direct attention to the outstanding work of the Royal Canadian Mounted Police in tracking down and arresting traffickers in Canada. There have been some of the country's most spectacular prosecutions made against traffickers by the R.C.M.P., and contrary to general belief, some of the biggest traffickers have been arrested and sentenced to long penitentiary terms. In two prosecutions in Vancouver some years ago, two of the ten most wanted criminals in Canada were convicted and sentenced.

The friction between the syndicates in Vancouver was kept more or less below the surface until last summer, when a certain individual was attacked and severely beaten. At this time, the illicit drug traffic in Vancouver was mostly under the control of two factions, and in addition, two other men known to both police forces were operating independently, although, of course, on a much smaller scale. In September, 1954, the body of a man identified as Daniel Brent was found on the 10th green of the University Golf Course, just outside the city limits of Vancouver. There was a bullet hole in his back, and two others in his head. This man was a suspected distributor of drugs, and some

time after his death the R.C.M.P. recovered a large quantity of heroin (30 ounces) from a safety deposit box rented in his name. This violence flared again in November with the attempted murder of another man, and as two men are now before the courts in connection with this, I can make no further comment.

On February 15, 1955, shortly before 8:00 p.m. a man left his home in Vancouver and when he entered his car which was parked on his driveway and turned on the ignition switch, he touched off a heavy charge of explosives which had been placed on the ground under the right-hand side of the driver's seat. The car was demolished and the man was severely injured, suffering the loss of his right leg and other injuries. I think evidence will be forthcoming in a trial shortly which will indicate that this injured man was also connected with the illicit drug traffic. You can appreciate the great difficulties experienced by the police in their efforts to detect and apprehend the persons responsible for these acts of violence, and it is underworld gossip that this warfare is by no means at an end, and other attempts on the lives of members of the rival organizations can be expected.

This, then, Mr. Chairman, is the situation which you and the members of your Committee will find existent in the city of Vancouver, and I assume it will be in order for me to conclude by outlining what the police in Vancouver think is the only possible solution. Our suggestions are drastic, and no doubt will be countered by criticism from other groups. The cost may be considered very high, but the taxpayers are paying a tremendous cost on account of this problem now.

Briefly, our suggestion is this. Recognizing that addiction breeds addiction, the addict is dangerous to society for he is the chief source of creating new addicts. Therefore, we should not be worrying too much about the confirmed addict. Our main concern should be for the well-being and protection of the persons exposed to his evil influence. To stop the spread of addiction, we must get rid of the addict. There is only one effective way to do this, and that is to remove all convicted drug addicts from society and segregate them in an institution far removed from any large centre of population. A suitable location for such an institution would be an island large enough for the development thereon of a colony farm for dairying and the growing of crops in sufficient quantity to provide certain staple foods for the addict population. An island would render expensive security arrangements unnecessary, and in addition, the buildings erected thereon could be of a type to conform with any ideas that might be put forward by those who are opposed to the idea of imprisonment and are eager to attempt rehabilitation. In fact the government could staff such a colony, working on rehabilitation ideas, and research could be conducted in attempts to find a cure for these unfortunate people under conditions most conducive to success. Instructors could be provided to teach at least a percentage of them a complete trade, and useful employment for many of them would be found in maintenance work on the buildings and in the dairying and general farming.

It has been said that enforcement of the Drug Act is not the answer to the problem, and if by this is meant the imprisonment of addicts in our jails and penitentiaries, I can fully agree. Our own experience most definitely shows that even after long terms of imprisonment, up to as much as five years to our knowledge, the criminal drug addict upon his release will immediately go back on drugs. This means, then, that those sent to our colony farm institution would have to be detained there for a long period, and a minimum of ten years is suggested. As research workers, psychiatrists and other members of the staff progressed with their rehabilitation efforts, there is no reason why some system of parole could not be worked out, with the parolees reporting to medical men for examination at regular intervals.

Coincident with the removal of the addict from society, municipal police forces of the large cities affected by this problem would set up a detail of officers trained in narcotic enforcement. These men, in co-operation with the R.C.M. Police would concentrate without let-up on the detection and apprehension of peddlers who might be attempting to create new trade. Such persons, upon conviction, should receive the maximum imprisonment as provided under the Opium and Narcotic Drug Act.

The police feel that with the adoption of these measures, the problem of narcotic addiction would be quickly and effectively overcome. We feel too that the colony farm arrangement is the only one which would enable the rehabilitation and research workers to carry out an effective programme.

Now, Mr. Chairman, the police know there are many people who are going to throw up their hands at the very idea of such a solution and say it is impracticable. But let us stop and think a minute. Upon the outbreak of World War II, we had in our midst in Vancouver a large number of residents of alien birth, whose presence in the city in time of war was considered dangerous to the safety and security of our citizens and country. Very quietly, and without any fuss, members of the federal and municipal police rounded up these aliens in the space of a few hours, and they were removed and established as a group in an isolated area far removed from the city. Up to the time of their removal, these people had all been gainfully employed and were therefore making a useful contribution to the economic development of our community and country. Is there anyone who can honestly say that the present concentration of drug addicts and peddlers in our midst is not a serious threat to the safety and well being of our citizens? And is it not true that instead of contributing to the economic development of our community as was the alien, the depredations of the criminal drug addict are resulting in heavy economic losses? I am sure that such a plan, holding out as it does, the hope of preventing increased addiction amongst the coming generation, and bringing at least some relief to the businessman, storekeeper and taxpayers from the staggering cost of crime, is worthy of the most serious consideration.

I believe the cost of such a plan would be largely offset by the savings effected in other directions. Apart from the monetary consideration, if such a project should prove successful, and the number of addicts in Canada is sometime in the future reduced to the level found in other countries, then the value of such a plan would be incalculable.

Senator HODGES: That is a very splendid brief.

Senator BAIRD: Yes.

Senator HOWDEN: I should like to say that this is the most comprehensive statement we have had. It gets its teeth thoroughly into the problem. It advocates the only plan that I have ever dreamed about, that of gathering these people together and putting them somewhere where they cannot escape. I should like to congratulate Mr. Mulligan for his very excellent submission and I should like to ask him if in his entire experience he has known of a reformed addict?

Mr. MULLIGAN: No, sir.

Senator HOWDEN: That is my belief too.

Senator HODGES: I notice that in the cases you have quoted several of the people did not become addicts until after they had been placed in penal institutions.

Mr. MULLIGAN: That is correct.

Senator HODGES: It is your opinion that criminals who go into institutions, who are not drug addicts, are likely to be brought into addiction because of their contact with drug addicts already in these institutions?

Mr. MULLIGAN: Absolutely. However, usually they start in crime as juveniles and at that time they meet and come into contact with drug addicts.

Senator HODGES: I realize that, but they do come into contact with confirmed drug addicts already in penitentiaries and other penal institutions?

Mr. MULLIGAN: Yes. There is no segregation.

Senator HODGES: There is no treatment given in the penal institutions, is there?

Mr. MULLIGAN: At Okalla in British Columbia some medical treatment is being given to a limited degree.

Senator HODGES: But there is no long-term treatment given.

Senator TURGEON: Has that colony suggestion you make ever been carried out, to your knowledge?

Mr. MULLIGAN: No.

Senator BAIRD: Is that not the scheme at Lexington, Kentucky?

Senator HOWDEN: Is it not a fact that so far in Canada we have not had a place where these people can be confined and treated.

Mr. MULLIGAN: That is correct.

Senator GERSHAW: On page 4 of your brief it is stated: "The survey also showed that 54.5 per cent of these addicts started using drugs at an average of 17.4 years—juveniles even then". I should like to ask if any of those are connected with high schools? What has been your experience?

Mr. MULLIGAN: No sir; very often in Vancouver we have received information that drugs are reaching into the high schools, but every investigation we have made has shown that such an assertion has been unfounded.

Senator GERSHAW: On page 12 of your brief it is stated: "There is only one way for them to obtain this money, and a conservative estimate of the equivalent cost in crime would be \$10 million." Could you give us a breakdown of that amount? How would that \$10 million be made up?

Mr. MULLIGAN: You would find the answer, sir, if you got the figures from the large departmental stores in all cities—Vancouver particularly—as to their losses resulting from shoplifting. The figure would stagger you.

Senator HODGES: Are the majority of shoplifters drug addicts?

Mr. MULLIGAN: Yes.

The CHAIRMAN: How do they know for sure that most of the shoplifting is done by drug addicts?

Mr. MULLIGAN: We have a close liaison with the departmental store detectives. We exchange information and we give them photographs of known addicts. The store detectives patrol their stores and watch for the addicts coming in, and whenever they can they turn them back from entering the store.

Senator QUINN: Following up what Senator Hodges said, I suppose many of the addicts become addicts before they are confined in penal institutions?

Mr. MULLIGAN: Yes.

Mr. LIEFF: I wonder if you would enlarge on the phrase "many irresponsible teen-agers" on page 14 of your brief. You will find it at line 4. Would you have any idea of the numbers? Would you give us some idea of the juvenile group that might be addicted at the present time?

Mr. MULLIGAN: During the past years we have had a difficult problem in Vancouver with respect to juveniles. Some five years ago we became aware of the serious problems of gangs. Our problem was similar to that encountered by the city of Toronto just after the war, in 1946 and in 1947. Groups of

adolescents formed gangs. In our department we set up what we called a "youth guidance detail". This was established in March of 1950. Actually we were not thinking too much of guidance then because of the acts of vandalism being perpetrated by these young gangs. We set up this detail to stop that sort of thing, and after we did stop it to a great extent I realized that this detail would have to become a permanent part of our police organization, and I changed the personnel of the men, appointing persons to the detail who had an aptitude for dealing with youth and who were interested in sports and youth clubs. We tried joining with other organizations to divert these people from the trouble they were causing to proper recreational channels. During the five years that this detail has been in operation in Vancouver we have built up a file in our records, and at this time the file contains a list of 7,500 names of boys and girls of adolescent ages, between fifteen and eighteen, who have been in trouble. Of that list of 7,500 there are approximately 1,500 boys and about 700 or 800 girls who have been repeatedly in the hands of the police for their continued bad behaviour. Boiling it down still further, we have a list of about 150 boys and approximately 50 girls whose pattern of behaviour has been so bad and they have been before the juvenile courts so often that they have been transferred to the ordinary courts. The judges thought it was in the best interests of the community to have these people referred to the ordinary courts. They form the group I am thinking about.

Senator HODGES: In breaking down that group do you find many of them have tried drugs or are taking drugs?

Mr. MULLIGAN: No, Senator Hodges, there was no indication of that.

Senator HODGES: Do you agree that they are susceptible?

Mr. MULLIGAN: Yes, they would be very susceptible.

Senator HODGES: You have not found any evidence of drug addiction?

Mr. MULLIGAN: No.

Mr. LIEFF: If I may just interject a question here. Would you care to estimate the number of addicts in Vancouver who could be classed as juveniles? You have mentioned three in your table. Is that the figure?

Mr. MULLIGAN: No, it is more than that. I shall try and arrange on your arrival in Vancouver to have a list of known juvenile addicts.

Senator HOWDEN: It is your opinion, of course, that when the market is removed the traffic will dry up?

Mr. MULLIGAN: Oh, yes, absolutely. It will wither on the vine.

Senator BAIRD: I do not quite agree with that. I think the pressure from these drug people is such that instead of allowing it to dry up, the tendency will be to bring in a lot more.

Mr. MULLIGAN: There are the two police forces, which should be enough, in the large centres, such as Vancouver, and after the market is removed, I do not think there would be any trouble.

Mr. LIEFF: I wonder if you could help us by telling us what luck you have had with respect to the prosecution of the receiver of stolen goods?

Mr. MULLIGAN: Well, we have done all right in that respect, although I would point out that it is a difficult charge, too, because when an accused gives a reasonable explanation of why he has it in his possession, even though the court does not believe it, his explanation must be accepted.

Senator BAIRD: I understand that some of the stores have lost as much as \$300 a day in Vancouver.

Senator HODGES: May I ask a question? You quoted the number of convicted drug addicts, and suspected drug addicts. Do you think there is a very big fringe of addicts outside of your suspected list who have not come within your purview at all

Mr. MULLIGAN: No, I think those two lists cover them accurately.

Senator HODGES: You think the combined police force of Vancouver know the full number of suspected addicts?

Mr. MULLIGAN: Oh, yes, on account of surveillance, you are bound to see them moving around.

Senator HODGES: Yes, but they might move in circles not known to the police necessarily. I am not talking of the criminal addicts or suspected addicts, but do you think there are a number that have not yet been suspected?

Mr. MULLIGAN: No. I would say that shortly after the arrival of such a person in Vancouver he would be noticed very quickly.

Senator HUGESSEN: Following upon that question, I gather that your general statement is that the crime comes first, and then the drug addiction; the man becomes a criminal and gets into criminal society first?

Mr. MULLIGAN: Absolutely.

Senator HOWDEN: I would like to ask what I think is rather an important question. Assuming you were taking in a large number of unconfirmed addicts, do you not think that their perpetual and constant abhorrence of the idea of being unable to get the drug—if you treated them well and permanently cured the habit, or at least cured them for the time being by removing the habit, and having taken that dread out of their lives, particularly the young people—they would probably remain free from the drug?

Mr. MULLIGAN: No, sir.

Senator HOWDEN: You do not think so?

Mr. MULLIGAN: No, sir.

Senator HOWDEN: You do not think there is any cure, except to shut them up?

Mr. MULLIGAN: That is the only solution I can think of, unless medical science in its research may come across any cure.

Senator BAIRD: But they have not found it?

Mr. MULLIGAN: No, they have not found it.

Senator HOWDEN: I don't know about that.

Senator HAWKINS: An important thing that was brought out yesterday in committee was that the Narcotics Control Division have tremendous sources of information as to who are using drugs, and for what purpose, whether for exhilaration, or for medical purposes. It is a most complete system of detection.

Mr. MULLIGAN: I am aware of that, sir. There is a very close liaison between Mr. Hossick's department and the R.C.M.P. and ourselves with respect to the movement of people.

Senator HAWKINS: Because, after all, that is where the information comes from. That is one source of information that must be very vital. I was surprised to learn yesterday, for instance, that in the legal distribution of drugs, if a doctor, for example, is getting a grain, or perhaps three or four grains of heroin, he has to tell where it is used, and who uses it, and for what purpose it is to be used; and when there are six or seven of these grains used, it is tabulated, and they want to know what he is using it for.

Mr. MULLIGAN: My worry is the crime, the addict, and the trafficker, and the violence which occurs as the result of this problem.

Senator HAWKINS: Those people might be a higher social level of addicts, and they would be known right off the bat when they are getting three or four shots a day?

Mr. MULLIGAN: Oh, yes.

Senator HOWDEN: My information is that heroin is prohibited on the Canadian market and that not even medical men are allowed to use it.

Mr. MULLIGAN: Yes, I believe that is so.

Senator HOWDEN: It is completely outlawed.

Mr. MULLIGAN: I believe so.

Senator LEGER: You suggested an institution.

Mr. MULLIGAN: Yes, an institution.

Hon. Mr. LEGER: The man would be sentenced there for two or three years or for as long as a doctor would say he was cured?

Mr. MULLIGAN: Yes, I would say so. It must be a long time.

Senator HODGES: Ten years.

Mr. MULLIGAN: I suggested a ten year period because of the security and correction required.

Senator TURGEON: Your suggestion includes the administration of drugs temporarily?

Mr. MULLIGAN: To give them drugs at the institution? I would say that is a matter for the medical authorities. We would not make any suggestion.

Senator TURGEON: Under your plan the medical authorities have the right to?

Mr. MULLIGAN: If they thought so.

Senator GERSHAW: I wonder if the witness would agree to this: While confirmed criminal addicts may be almost impossible to cure,—and maybe as a general rule they cannot be cured—would the witness not agree that young addicts and those who had only acquired the habit recently, and those who were in good health could be cured?

Mr. MULLIGAN: I would hope so.

Senator HOWDEN: That is my idea. I think their abhorrence of being under the tyranny of drugs, if removed, would probably free them from the habit.

Mr. MULLIGAN: Of course, I would remind you that I am a policeman and not a doctor.

Senator GERSHAW: You made the statement that none could be cured.

Mr. MULLIGAN: I am speaking of confirmed addicts. You are speaking of just young people starting out.

Senator HOWDEN: I asked you about unconfirmed addicts.

Mr. MULLIGAN: I am sorry. The senator was mentioning young people—teen-agers.

Senator HOWDEN: And I believe unconfirmed addicts can be cured. In fact, I know they can.

The CHAIRMAN: You spoke of experts, a few moments ago, going east, and coming from east to west.

Mr. MULLIGAN: We got that information from the R.C.M.P. officers, and our own officers locally pick up that information from the street. I do not know of its authenticity.

Mr. LIEFF: I believe, Mr. Mulligan, you told us that you work under a police commission?

Mr. MULLIGAN: Yes.

Mr. LIEFF: And I suppose that is similar to Police Commissions elsewhere.

Mr. MULLIGAN: Yes. The chairman is the mayor of the city, and a county court judge, and a police court magistrate.

Mr. LIEFF: And I suppose you make auxiliary reports giving the crime figures, and so on?

Mr. MULLIGAN: Yes.

Mr. LIEFF: Would it be helpful to this committee when we get to Vancouver to have some of the recent annual reports?

Mr. MULLIGAN: Yes.

Senator HODGES: Is there not a summary of those reports incorporated in your brief?

Mr. MULLIGAN: No, they just deal with the activities of the year. I think the appendix reports would give you the breakdown on the age groups, and the number of offences over the years. That is to be found on the last page.

Senator HODGES: Just to follow up what Mr. Lieff said about reading the reports, I am thinking that when we get to Vancouver we will have to hear so many witnesses that we do not want to spend the time reading reports.

Mr. MULLIGAN: No; the annual report does not deal with the drug problem.

The CHAIRMAN: Did you suggest that you had some members of your staff who were familiar with the drug problem, whom we should hear when we are in Vancouver?

Mr. MULLIGAN: Yes; I am very anxious that this committee see some of our local officers who have been doing enforcement work for many years. I am sure they can give you some practical and factual information.

Senator HOWDEN: You will see that those men come before us.

Mr. MULLIGAN: Anyone on the force will be available to you, and I will give Mr. Chairman a list.

Senator HODGES: I hope we will be able to see one of these addicts—particularly the one you referred to who is willing to come before us.

Mr. MULLIGAN: I know there are many who will be glad to appear.

Senator HODGES: But you say they do not always want to tell the truth.

Mr. MULLIGAN: Don't put too much weight in what they say; however, you can use your own judgment.

Senator TURGEON: You say some would be anxious to appear?

Mr. MULLIGAN: I am sure some will appear.

Senator TURGEON: Does that interest come from the use of drugs?

Mr. MULLIGAN: They would like to appear before the committee.

The CHAIRMAN: In your conversation with drug addicts, do most of them give the idea that they are in favour of free drugs?

Mr. MULLIGAN: Oh yes; all they want to know is when they are going to start giving it to them.

Senator BAIRD: The amount of money that you say is required per day and per year to keep people supplied with drugs seems to me astronomical. Where do they get it?

Mr. MULLIGAN: That is a conservative estimate.

Senator HODGES: They get it from bank robberies.

Mr. MULLIGAN: Prostitution, prowling of apartments and hotels.

Senator HODGES: That is what really accounts for the increase of crime in Vancouver in your opinion?

Mr. MULLIGAN: Yes, absolutely.

Senator HODGES: And it has increased tremendously over the past few years.

Mr. MULLIGAN: Yes.

The CHAIRMAN: You believe that the great increase in crime which has arisen in Vancouver is attributable to the drug traffic?

Mr. MULLIGAN: I blame the drug traffic for the great increase in our crime.

Senator LEGER: They start taking drugs, and then they turn to crime.

Mr. MULLIGAN: Yes. I know that when the day comes when these people are removed from society, are isolated or quarantined, the crime in my city will drop to its normal level.

Senator HODGES: But you are not prepared to say that every crime that comes before your court is due to drug addiction.

Mr. MULLIGAN: No. There have been people who say that the drug addict is not a criminal and does not commit certain crimes. However, every day I see on our court list in Vancouver the names of drug addicts charged with the whole variety of crimes that I have mentioned, such as theft, robbery, breaking and entering of stores, homes, and the strong-arming of drunken people, and even hold-ups.

Senator TURGEON: I would like to direct your mind to one thought. You say that the main cause of the robberies in Vancouver is drug addiction.

Mr. MULLIGAN: I have mentioned the figure of 60 per cent, and I will stay by that.

Senator TURGEON: On the other hand, you mentioned the formation of youthful organizations, whose members were not given to drugs and never used drugs. I take it that in itself would lead to other crimes, such as robbery and so forth?

Mr. MULLIGAN: Yes, sir.

Senator TURGEON: Yet these people are not afflicted by drugs.

Mr. MULLIGAN: No.

Senator TURGEON: What about the relationship?

Mr. MULLIGAN: These youthful gangs have as their main crime the theft of automobiles. I am sure there are more cars stolen in Vancouver than in any other city in Canada. They pick up the car somewhere and take their girl friends and go joy riding, and in the meantime commit some other crime.

The CHAIRMAN: For the past three years to my knowledge there has been broadcast over the air every morning the number of cars stolen and the license numbers of those cars. My question is, what percentage of those cars do you recover?

Mr. MULLIGAN: The recovery is very good. The local radio stations have been of great assistance to the police in that respect.

Senator HOWDEN: These people usually abandon the cars, don't they?

Mr. MULLIGAN: We have an average of 150 cars a month stolen in Vancouver, and we pick up 147 or 148 of them the same month.

Senator HODGES: Do you think any of them are engaged in the drug traffic?

Mr. MULLIGAN: No, I think the greater percentage of them are young people.

Senator HODGES: Just joy-riders.

Mr. MULLIGAN: Yes.

Mr. LIEFF: Are the more violent crimes committed in Vancouver the work of addicts, top-level dealers, or people associated with the top-level of the drug traffic?

Mr. MULLIGAN: No. I must remind you that in addition to the addict we also have some professional criminals who are not addicted, but who commit a great many of our major crimes. I think that by the time your committee comes to Vancouver we may be able to learn about the connection between the drug traffic syndicates and some of the bank robberies that troubled us so much last winter.

Senator HAYDEN: By that you mean that the people who are principals in the drug traffic may be associated with those who are principals in the more serious crimes?

Mr. MULLIGAN: That is correct; these syndicate members are associated with the active major criminals.

Senator HAYDEN: And the actual operators or the ones who do the job may receive as their reward a very small portion of the loot.

Mr. MULLIGAN: That is correct.

Senator HAYDEN: I was wondering how you arrived at the figure of 60 per cent of your crimes having originated from the use of drugs.

Mr. MULLIGAN: That is based on the monthly volume of crimes in our city; we break down the crimes such as thefts, burglaries, hold-ups and so on, and we have estimated that 60 per cent of such crimes have been committed by drugs addicts.

Senator HAYDEN: I have always been under the impression that drug addicts would do things that would get them money, but they would not engage in any major crime, that the addiction more or less kept them away from that kind of operation.

Mr. MULLIGAN: That is the case.

Senator HODGES: What do you mean by major crimes?

Mr. MULLIGAN: I am thinking of bank robberies, for instance.

Senator HODGES: Don't you think they would do that to get money?

Senator HAYDEN: That may be so, but I did not think that the nature of the drug addict was such that he would choose that kind of operation to get money. I have seen and prosecuted a great many drug addicts and, for the most part, they appeared to me to be the kind of person who would commit any low sort of crime that would get money for them with which they could buy drugs, but I could not visualize them being engaged in any crime of violence or having the ability to carry out a bank robbery.

Mr. MULLIGAN: I would agree that a large percentage are of the type you have described, but among them there are those who will commit the major crime.

Senator HAYDEN: I would think they would be the exception.

Mr. MULLIGAN: They are the exception rather than the rule.

Senator HOWDEN: The one idea of the drug addict is that he will not find himself without drugs and he will do anything—that is anything—to get them.

The CHAIRMAN: May I ask whether when drug addicts appear in court and have money are they supplied with legal counsel to represent them?

Mr. MULLIGAN: They very often are. One point I should like to bring to your attention as to these people not having any money is what the city prosecutor and I found in Vancouver. He and I complained to the Police Commission and to City Council about the large number of drug addicts whom

we found were obtaining social assistance in the city and were registered for relief. We found that they had no more need of that money than the average citizen who was gainfully employed; they merely went to the city for social assistance to avoid being arrested by the police for vagrancy and being put away for a time, when we could not get evidence on them for any other crime. Steps are now underway to correct that situation.

The CHAIRMAN: My thought is, if a drug addict had his legal counsel hired and paid for to represent him in court, would that in any way lead you to the higher ups? It might indicate that those people higher up in the drug traffic were providing counsel.

Mr. MULLIGAN: I don't think so, Mr. Chairman. I don't think the higher-ups would bother about assisting anyone; and they certainly would not give anyone away.

Senator HODGES: I notice the Chief does not agree with these free clinics?

Mr. MULLIGAN: Definitely not.

Senator HODGES: And yet it was a Vancouver group which brought in the suggestion of free clinics. Did they consult you?

Mr. MULLIGAN: I was a member of the Committee, and in the vote I was the only objecting member.

Senator HODGES: That is interesting, because I wondered, in the face of what you have given us, how they would come to the conclusion they did.

Mr. MULLIGAN: I was a member of that Committee. I was there, I think, to supply statistical information and outline some of the problems; and I debated that point with them, and when the vote was taken I was the only one who voted against it.

Senator HUGESSEN: Is there any precedent for that method of dealing with drug addicts,—in any other country?

Mr. MULLIGAN: I don't know.

Senator HUGESSEN: That is, having a clinic where they can get their drugs?

Senator HODGES: We have been told that Britain has a free clinic. I am rather vague about this, because so much has been written, but it seems to me that I have heard that Britain has a free clinic.

Senator GERSHAW: Forty-four of them were established in the States in 1915. By 1924 they were all closed, because they found that it just meant an additional supply of drugs.

The CHAIRMAN: Is there a place, Mr. Hossick, where they are carrying on a free distribution of drugs?

Mr. HOSSICK: I know of no other place in the world, senator, except the trial clinics in the United States. There are no clinics in the United Kingdom of the kind we are talking about.

The CHAIRMAN: We were just wondering about that. A group in Vancouver have got some information and are putting forth the plea for free drugs, in which they seem to believe strongly.

Senator HODGES: I do not think there is any doubt they will bring that information before us.

Senator HAYDEN: Are you able to determine, when a man comes into court, whether he is, or was, a drug addict?

Mr. MULLIGAN: By examination of the man? Well, we do examine their arms to see if they have the needle marks.

Senator HAYDEN: That indicates that he was; but actually what I have in the back of my head is that, if we reached the conclusion that one way of dealing with this problem would be to lock up every addict, and the law does not permit that now, to make provision so that you can take him out of circulation and keep him out of circulation; then the problem comes of proving that he is a drug addict.

Mr. MULLIGAN: This list which I submitted to the Chairman of the convicted addicts gives a breakdown of the number of times they have been convicted.

Senator HAYDEN: But I am trying to make it easier to corral and keep them.

Mr. MULLIGAN: We have plenty to start with.

Senator HAYDEN: Usually you convict on evidence satisfactory to the magistrate that he is a user of the drug. You have caught him in the act, or something like that.

Mr. MULLIGAN: You mean, to go ahead, and not only segregate convicted addicts?

Senator HAYDEN: Yes.

Mr. MULLIGAN: I see. You would have a fight to do that.

Senator GERSHAW: There would be withdrawal symptoms. I understand that.

Mr. MULLIGAN: There would be a lot of objection to that.

Senator HAYDEN: Objection or not, this is a serious business.

Mr. MULLIGAN: Not objection from the police: you would get all the help you wanted.

Senator HAYDEN: If intelligent treatment would take them out of circulation, let us have it, by whatever means it can be done.

Senator HOWDEN: If the federal and provincial authorities had a plan like that on which they could agree, perhaps we could put it over.

Senator BEAUBIEN: Do you agree with Senator Howden that there is no cure for drug addicts except the suggestion you have made, of isolating them?

Mr. MULLIGAN: I don't know whether this is the only suggestion. That is what the police think. In my twenty-eight years I have never known of a rehabilitated addict.

Senator HUGESSEN: You confine that to heroin?

Mr. MULLIGAN: Yes, sir.

Senator HOWDEN: We have never had in Canada a proper method of controlling or treating these drug addicts. That is what I said two or three years ago. And we will never get anywhere until we do take them out of circulation,—never.

Senator HAYDEN: I do not think we need to be nice and refined about the methods we use.

Senator HOWDEN: I do not think so either. I think, as was suggested in the paper, that some of them could well be hanged.

Senator HODGES: I want to put this on record: I was incorrectly reported in the Vancouver papers as having said that I was in favour of hanging drug peddlers. There was a column in one of the papers condemning me for being inhuman. What I said was that I thought that, if hanging were ever justified, it was justified in connection with the conviction of the heads of the dope rings. I might as well get it right now. I did not say that every little peddler should be hanged, although sometimes I think we might solve the problem by doing that.

Senator HOWDEN: I don't think any punishment is too severe for that . . .

The CHAIRMAN: Any other questions, honourable senators, to put to the Chief while he is here? . . . If not, I want, on behalf of the Committee, to thank him most sincerely for his attendance and presentation.

One last injunction: our next meeting is on the 18th of April, in Vancouver. I trust we shall have a one hundred per cent attendance.

Whereupon the committee adjourned.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

EVIDENCE

VANCOUVER, B.C., Monday, April 18, 1955.

The Special Committee on the narcotic drug traffic met this day at 10:00 a.m.

Senator REID in the Chair.

The CHAIRMAN: Honourable senators, in welcoming you to the Coast this morning, I might say that we have with us His Worship, Mayor Hume, who has taken quite an interest in the deliberations of the Committee and who wishes to extend to us a word of welcome.

Mayor HUME: Senator Reid, most distinguished Senators, ladies and gentlemen:

I want to thank you very much this morning for being with us. I also want to thank you very much for coming to British Columbia.

When this matter was talked about, I suggested to Senator Reid that I would like to have the enquiry held in British Columbia for the reason that many peace officers will be giving evidence and several Magistrates will be giving evidence, together with many others who would have difficulty if the enquiry was held in Ottawa. So, on behalf of the citizens of Vancouver, I wish to thank you most sincerely for being here this morning in connection with this most important subject—narcotics. The Mounted Police and our city police have been doing everything possible, working long hours, long days, and sometimes seven days a week, and they have been making a good job of it, working as a unit. But we, the citizens of Vancouver, need your help and need your suggestions I might add, to the problem of narcotics and other matters tied up with narcotics in the city of Vancouver.

Now, a lot of things have been said about Vancouver, but I would like to say a good thing or two about the City of Vancouver. I would like to tell you that last week, Vancouver had a birthday and at that time it was sixty-nine years of age. It has progressed very rapidly in sixty-nine years. In fact, it is one of the young cities of British Columbia and one of the young cities of the Dominion of Canada. Last year we were entrusted with the British Empire Games and the citizens of Vancouver worked as a unit to make those games successful. And at the Vancouver hotel, at one time, we had over three hundred people—newspaper men, and radio men, television men, photographers—telling the world about the City of Vancouver. We were told when the Games were completed, by the committee from the British Empire Games in London, and also by the Duke of Edinburgh and Viscount Alexander, that the Games were the very best ever. Now, we were selected—it was agreed on that the Games should be held in the city of Vancouver. However, I think you will all agree it was a job well done.

Vancouver is a city of fine homes, fine churches, an all year-round harbour; it has fine golf courses, wonderful schools, fine hospitals; you can enjoy fishing.

Last month, in the City of Vancouver, a committee from all over Canada arrived in Vancouver to discuss the most important thing which happens one day in the year and that is the Grey Cup. And all the delegates from all the different Provinces banded together as a unit so that we could have the

Game in the West. Now, had we been as bad as sometimes thought of we would never for one moment have been recognized by being awarded the Grey Cup Game.

I sincerely hope that you will take some time out while this enquiry is on—and I may assure you gentlemen that the police force, the officers, cars, my office, is at your disposal while this enquiry is here. We will do everything we can to assist in any way we can in order that you might help us to bring a definite solution to the problem of narcotics.

But while you're here, I would like to tell you also that the people of this city have faith in a good, clean city and the building permits for this year alone will be around ninety-four millions of dollars that they're spending right here. Right across from the Vancouver Hotel will be a new office building, twenty-one stories. Adjacent to the Hotel Vancouver is a new library, and so on. The people have been very worried about this question of narcotics and rightly so, because we've had murder, we've had attempted murder and we've had all kinds of other things. So I say this morning, ladies and gentlemen, of this most important committee, I want to again thank you for the expense you've saved us, for the time you've saved us, and for what you are giving in the way of time and everything else to help solve this important subject in the city of Vancouver, because, I think you'll agree with me, we have fine Mounted Police, and we have fine city police and we have the utmost of confidence in them and I feel sure at the time this enquiry is finished you may have some solution to offer that may help us in the Province of British Columbia.

Thank you very much Senator Reid.

The CHAIRMAN: Your Worship, Mayor Hume, may I, on behalf of the Committee, say how much we appreciate your presence with us this morning, and appreciate the very fine words of welcome which you have given us.

I would like to point out that the Committee came to this city due to the great problem facing the people of this city in regards to the narcotic drug problem. We have come with a very open mind. We will endeavour to make the fullest enquiry whilst we are here. One personal disappointment, so far as I am concerned, is the fact that we did think, with so many drug addicts, that many of them would have come forward to give their testimony and I am just wondering if there is not a sit down strike with the drug addicts who hesitate to come before us; however, be that as it may, we have a full week of enquiry with us. I don't think there'll be much time through the day for, shall we say, visiting around, but whatever we can do in that way we'll endeavour to show those who are here for the first time.

I think it will bring our efforts—at least I hope so—to a very successful conclusion may I say, although it will take some time to cover all of the ramifications involved in this great problem.

We are just about to call our first witness, but again may I say thanks.

MAYOR HUME: Thank you, sir.

The CHAIRMAN: Gentlemen, our first witness this morning is Dr. R. G. D. Stevenson. Doctor, will you come forward and—

Mr. A. H. LIEFF, Q.C.: Doctor, I understand that we have been getting your initials wrong, that the name is George H.—is that right?

Dr. STEVENSON: That is right, sir.

Mr. LIEFF: And for the record, perhaps you will correct me if I haven't the information correctly doctor, but I understand that for the past thirty-five years you have been a practicing physician, specializing in psychiatry.

Dr. STEVENSON: That is right.

Mr. LIEFF: And that for some eighteen years you were Professor of Psychiatry at the University of Western Ontario, and that now you are the Director of the narcotic drug addiction study at the University of British Columbia.

Dr. STEVENSON: That's right.

Mr. LIEFF: That is correct. And associated with that, you are the Research Professor of Psychiatry at the University of British Columbia.

Dr. STEVENSON: That is right.

Mr. LIEFF: Thank you very much.

Senator BEAUBIEN: May I point out that we were handed an article—a paper, written by Doctor Stevenson at the first sitting of the Committee in Ottawa. It has not been made officially a part of the record, but perhaps we might now make that particular paper—

The CHAIRMAN: Have we any extra copies?

Mr. LIEFF: Perhaps we have. Perhaps there are some available that could be gotten before too long—

Dr. STEVENSON: Yes, Mr. Hossick has five hundred of them.

Mr. LIEFF: We have five hundred in Ottawa, but are there any available readily here.

Dr. STEVENSON: Yes, we can get some if you need more.

Mr. LIEFF: Very well, perhaps we might have a few.

Dr. STEVENSON: A dozen—

Mr. LIEFF: A dozen or more. Thank you doctor. So that, we are now producing this paper to make it officially part of the record.

The CHAIRMAN: Is it agreeable that we put this as an appendix to our proceedings.

Hon. SENATORS: Agreed. (*See Appendix G*)

Mr. LIEFF: Dr. Stevenson has suggested that there is another paper by himself entitled "You Can Prevent Drug Addiction—and Cure Victims of Habit". This is a paper that we might put on the record now, with your permission, Mr. Chairman. There are copies available for everybody.

Hon. SENATORS: Agreed. (*See Appendix H*)

Mr. LIEFF: And perhaps at this stage, doctor, we might leave you at liberty to make a preliminary presentation in your own words and in your own way without any questions from me.

Dr. STEVENSON: Thank you, Mr. Lieff, Mr. Chairman, Ladies and gentlemen. The two papers which have been mentioned, the one on the argument for and against the legal sale of narcotics was published in the bulletin of the Vancouver Medical Society in January of this year at the request of the editor of that Journal, Dr. MacDermid. The other paper was published in the *Toronto Globe and Mail* on the 8th of February; it was written at the request of the Canadian Medical Association as a part of a public education series of papers that they have asked us to contribute.

Our Research project, under the auspices of the University of British Columbia was begun, as far as I'm concerned, the first of October 1953. That is the date I joined it. It had been set up originally at the request of the committee on addiction of the greater Vancouver Community Chest and Counsel, who had made—which committee had made certain recommendations, among them being that the University of British Columbia do a research study. As a result of that request, President MacKenzie of the University of British Columbia, set up a University committee and this committee—University Committee

—applied to Ottawa for funds to finance it for approximately a three-year period and Ottawa has supplied the funds and is continuing to supply them. And we are also receiving financial and other help from the Province of British Columbia through the Attorney General's department and Oakalla Prison Farm, through the courtesy there of the Attorney General and Warden Hugh Christie, from whom we have had very fine assistance and cooperation at all times. The Research team, as such, began on October 1, 1953, with my appointment. I was joined later—within the next few months—by a psychologist, Mr. Lingley, and a special worker, Mr. Fogarty, who has since taken another position and has been replaced by Mr. Trasov. We also have a part-time physician, Dr. Stanfield, who does our physical examinations and advises us on physical aspects of the problem. And we have a secretary, Mrs. Agnes Lambe. We are doing most of our work on addicts at the Oakalla Prison Farm and we are—we have offices there, space there, facilities there, and we are making various other studies in the field of addiction there and wherever we can find the material.

The project, as you will see, has been operating now about one and one-half years and it is expected to go on another year or so, so that we are in the position, perhaps, of giving you a report, some sort of a report, and answering your questions so far as we are able to, with our study only about half done. At the same time, we have quite a bit of material and quite a bit of work has been done in various aspects of the study. I should like to make it clear, however, that any opinions that I may be asked to express will be my own personal opinions and not necessarily the opinions of my colleagues as they may finally emerge when the study is completed. I take responsibility for them just as my own personal opinions at this time.

I am not submitting any formal brief, but I tried to anticipate what fields of questioning you might be interested in from me and have suggested and discussed with Mr. Lief and Mr. Curran on this matter, and I am prepared to make certain statements and answer your questions in this field or in any other field you would like to question me about, as far as I am able to answer.

Mr. LIEFF: Doctor, just by way of getting started, would you care to make a statement now on the following question. It's a very simple question: Why do people use narcotic drugs?

Dr. STEVENSON: Yes, I will try to answer that so far as I am able. With a number of these questions, I may say that the general public have certain ideas about them which are not always substantiated by proof and consequently I might deal first of all with some of the generally conceived ideas which in some cases, as I say, are not necessarily correct. For example, it is commonly believed that a lot of people get into the use of narcotic drugs by being seduced by avaricious unprincipled narcotic sellers. We haven't run into that problem scarcely at all in the approximately three hundred addicts that I have interviewed since I have been here, and only one person out of all that I have interviewed has indicated that he was approached by a person to buy drugs. Then, another point that one has heard mentioned from time to time, that some of these sellers, or "pushers" as they are commonly known as, circulate in the neighborhood of high schools and other places. We have had just no evidence from all the addicts to support that opinion either. And, I know the school people are very much concerned about this problem. We have found no one person in Vancouver who has started his addiction while he was attending a Vancouver school. Only in two instances, out of more than three hundred people, have I been told that it was known while they were still in school, that drugs were available in the area and that was just hear-say.

Senator HODGES: Could I interrupt, Mr. Chairman, at this point, to ask—you say no addict was found who started while in school. Would you extend that to say that no addict started while they were of school age?

Dr. STEVENSON: Well, I am not just sure what "school age" would mean—

Senator HODGES: I mean high school age—

Dr. STEVENSON: —we have had addicts who started their addiction at fourteen and fifteen and sixteen, but they were already out of school.

Senator HODGES: That's the point I wanted to have clear. Thank you.

Dr. STEVENSON: That would bring me, perhaps, to some of the things that impressed me as having importance as to why people do start drugs, and the first point that I would like to mention is the peculiar quality of certain drugs in their attractive effects. There are a number of drugs that give a very comfortable and pleasant feeling to people who use them, and I think perhaps we ought to think of certain quite commonly used substances not necessarily narcotic drugs, such as tobacco and alcohol, which do give many people satisfaction.

Senator HODGES: Tea and coffee?

Dr. STEVENSON: Tea and coffee, and the barbiturates and many other things, some of which have addiction possibilities.

Senator HORNER: Might I ask you—you are coming to that I suppose though—the question as I understand it, it is sometimes given in the case of pain and suffering and then, is that not the way the majority become addicts?

Dr. STEVENSON: No, that's the rarest way that people become addicted to drugs.

Senator HORNER: A doctor friend of mine told me that was the way—

Dr. STEVENSON: At one time, seventy-five—one hundred years ago, it was. In England for example, but it certainly is not the case in Canada today.

Senator LEGER: Very few cases.

Dr. STEVENSON: Very few cases. It's extremely rare. Now, you have had figures presented to you, showing that there are some five hundred people I think who are using drugs under doctors orders for medical reasons.

Senator HORNER: In—

Dr. STEVENSON: In Canada. But that doesn't apply to the—that is, they may be getting it, I know nothing about those cases, but the addicts that we are seeing here and in other cities and the police see, very rarely start their addiction for any physical reason.

Senator McKEEN: Mr. Chairman, just a correction there. I think that the witness meant seventy-five to one hundred years, but he said seventy-five hundred years.

Dr. STEVENSON: Well then the first thing that has to be emphasized is the drug itself. And the common drug of addiction in Canada and the United States is heroin, an opium derivative, and that people who take it for its pleasant effect find they need larger and larger doses and finally if they don't keep taking it, find they are physically sick. But the very pleasant, seductive quality of the medicine itself, of the drug itself, has to be given a prominent place in any study of why people take drugs.

Senator McKEEN: Just there, Dr. Stevenson, supposing a person was in perfect health would they get any pleasant effect by taking drugs, or if they were depressed or worried mentally, or unstable, would they get it as an escape?

Dr. STEVENSON: There is quite a variation in people and in the effect that a single dose of a narcotic drug has on a person. For example, morphine is given every day in general hospitals and the subject, sick person, taking it is conscious only of the relief from his pain. But these are the other people that

we are thinking about particularly here, they are not taking it for the relief of physical pain, they're taking it for their own mental comfort or pleasure or thrill or some one of those terms.

Senator McKEEN: There is not much pleasure for a person in perfect health to take them—

Senator GERSHAW: I wouldn't say that—not in my experience. I think under any circumstances where morphine or heroin is taken there is a pleasant effect as a result.

Dr. STEVENSON: I think that is correct. But when a person takes it for the relief of physical pain that is the experience he is especially interested in. And I think too, with the introduction of the drug itself, it should be made clear that there is nothing essentially evil about wanting or taking a chemical substance, whether that be aspirin, tobacco, alcohol or heroin.

Senator HOWDEN: None of the substances, such as alcohol and tobacco are comparable in the least degree with the opiates.

Dr. STEVENSON: I will come to that, sir. I am just saying that these are all medicines that people take for their own feeling of euphoria and that some people who don't get enough satisfaction from these milder things go on to stronger narcotics.

Senator HODGES: Would you include aspirin among that, doctor?

Dr. STEVENSON: People take aspirin for such things as headaches and relief of pain.

Senator HODGES: Yes, quite, but hardly for the pleasant feeling it gives, except for the relief from pain.

Dr. STEVENSON: That's it. Well that's—

Senator HODGES: I mean it doesn't give one a sense of exhilaration or—

Dr. STEVENSON: No, it's to remove an uncomfortable feeling.

Senator HODGES: Yes, quite.

Dr. STEVENSON: And narcotic addicts, of course, are trying to remove certain other uncomfortable feelings. They do have a lot of uncomfortable feelings.

The second point as to why people take narcotic drugs is the fact that narcotic drugs are available on the black market and I think it would be agreed that if there is no availability that there would be no drug addiction.

Then the third point, not counting doctors and nurses who have easy access to drugs, or people who are given narcotics for physical reasons, there are many people who begin narcotics from the, shall we say, the socially under-privileged group. Most of the addicts that we're seeing, come from the under-privileged and socially under-privileged people. They are people who have a strong curiosity, they are looking for new experiences, new thrills, and they take it in the first instance because they are seeking a new experience. They like the experience and they repeat it for its pleasant effects and commonly repeat it in increasing dosage. And then, in the third place, they continue on drugs after they are addicted and partly because of the great craving and liking they've developed for them, but more particularly because of their fear of being deprived of them and the sickness symptoms which result when they are deprived.

The next point as to why they take drugs, there are perhaps especially weak personality types. They are of average intelligence as a rule but they are emotionally immature, they have many child-like features, they want pleasure all the time, they live for immediate satisfactions, they have very little interest in planning for the future, they are restless, impatient, untrained and undisciplined people, they tend to be selfish, lacking in moral standards, lacking in a

sense of personal responsibility. They have expensive tastes but lack the economic means to gratify them legally. Few of them have learned a trade, and they crave change and variety and independence of boring routine.

Senator HOWDEN: You wouldn't say that a certain individual would have to be such a subject as you mention in order to become an addict however?

Dr. STEVENSON: No, addicts, however, largely have these characteristics, but there are other people too who have them who don't become addicts.

Senator HOWDEN: Yes.

Dr. STEVENSON: Then, the next point, these people that we're seeing who are using drugs have very largely been delinquent and poorly adjusted before starting drugs, and I suggest that the total causes of delinquency, whatever they may be, must be thought of as one of the predisposing causes of drug use, including poor home life and homes of low social and economic standard, delinquent and careless parents, depressed areas of certain cities and associating with delinquents personally.

In connection with this pre-existing group of characteristics, we find in our observation that a large proportion of them have been delinquent before they start on drugs. For example, seventy-seven out of the seven hundred that we studied had been known juvenile delinquents, and thirty-eight of them had been in reform schools, and seventy-two of the one hundred had court convictions before they started on drugs, so that delinquency has been a common pattern in many of them before they started on drugs. I may say that of the others, it doesn't necessarily apply that they hadn't been delinquent but we just haven't got sufficient data to say in which category they would be in.

Mr. LIEFF: In other words, doctor, they were delinquents first, drug addicts next?

Dr. STEVENSON: That's right.

Senator HODGES: That pattern follows pretty well through, does it, Doctor?

Dr. STEVENSON: Yes. You see here about three quarters of them had been delinquent or had definite conviction before they ever went on drugs.

Senator HODGES: Yes, but I mean, you took one hundred and you found seventy-seven had been delinquent, does that pattern follow through?

Dr. STEVENSON: It does, yes.

Mr. LIEFF: I suppose, the chances are that they might have remained delinquent whether they had taken drugs or not?

Dr. STEVENSON: I am not prepared to answer that.

Senator KING: Doctor, you made a statement there—some had been in reform school under care—were they addicted before that?

Dr. STEVENSON: No, they had been there before they went on drugs. And then—

Senator McKEEN: Have you any check on other areas whether that same pattern is true.

Dr. STEVENSON: We have certain figures because we are—but we're studying another group of people who are not drug users at Okalla, and we have certain figures on them and it is not as high as the figures just given you.

Senator McKEEN: What I meant, say in Eastern Canada, for instance—?

Dr. STEVENSON: No, I have no figures on Eastern Canada—

Senator McKEEN: Or the United States or England, or—?

Dr. STEVENSON: No, I have no figures, Senator.

Then, in addition to this common pattern of delinquency, there has been a large immoral tendency. This applies to both the men and the women—immorality—however one may want to define it—sexual immorality—has been common in a great majority of the group, and—

Senator HORNER: Would that be before or after—

Dr. STEVENSON: Before, this is all before they went on drugs.

Senator HORNER: Before they went on drugs?

Dr. STEVENSON: Yes. And more than half of them have been heavy users of alcohol before they went on drugs.

Senator LEGER: What percentage did you say there, sir?

Dr. STEVENSON: More than half.

Senator KING: What age are they, the older group?

Dr. STEVENSON: Well, I can give you figures as to the age they went on drugs too, but these are just figures—just a general statement as to their condition before they started to use drugs. And, of the people that we have studied at Oakalla, not one, I would say, has been a well conducted, moral, socially well adjusted person at the time he started on drugs. Then the next point, no one seems to start on drugs who is not in pretty close contact with the drug users, or with the drug itself. I am thinking there, in that second statement, of doctors who are in close touch with the drug itself and as you know professional people have a fair number of drug addicts. So that is an important factor, the close association with drug users or with the drug itself.

And then, the last point I would like to emphasize is that, although these points I have mentioned have all been on the surface, as it were, they have all been things that we are aware of, that some of these addicts for reasons, I might say deep psychological reasons which they don't understand themselves, and which perhaps the general public doesn't understand, dating from early childhood, perhaps as a result of faulty handling in the home, or inherited tendencies which they don't understand, there are certain individuals who feel a strong urge to do the anti-social thing as they get older, and although they might not themselves realize it, these deep seated psychological factors can also be reasons.

Senator HODGES: Doctor, what percentage would you say start drug addiction solely for the reason of a new thrill. I mean, in this day of tension, speed, and that sort of thing, do you find much of a proportion who don't come from poor homes, who come from better homes but who go in for starting drug addiction just for the sake of acquiring a new thrill. Have you any idea what proportion there is of that?

Dr. STEVENSON: Well, I don't know that I could say very exactly. A great majority of the people we are studying started for the reasons I have given.

Senator HODGES: Yes, I see.

Dr. STEVENSON: But about less than 10% start drugs to get away from alcohol.

Senator HOWDEN: Is it true that a good many addicts are made addicts by accidents in life and that sort of thing? Such as periods in the hospital during which drugs are administered, and having learned the extreme efficiency of the drug in dispelling pain and mental disturbance generally, their tendency is to approach the drug and obtain more contact with it in the future. I mean to say, is there not a large proportion of people that become accidentally addicts as compared to those who start out definitely with the purpose of obtaining addiction.

Dr. STEVENSON: Speaking from our experience at Oakalla, I would say that very few have started that way, or for that reason. Very few.

Senator HOWDEN: Very few have started what?

Dr. STEVENSON: Have started using narcotic drugs because they were in hospital or anything of that sort. They have started very greatly because of the desire for a new experience.

Senator HOWDEN: Doctor, I would take it—you mentioned there that underprivileged are the majority you thought. In my life-long experience there were a number of people without any reason in the world, who came from good homes, good education, druggists, and even some doctors I have known, and I would doubt that, throughout Canada, it is the under-privileged—perhaps more often it is the wealthy people.

Dr. STEVENSON: The people that have caused the problem here in British Columbia are not of the group you are speaking of. They are the group that you have had figures on—doctors, nurses, dentists, etc., but the people who are—

Senator HOWDEN: Druggists, veterinarians—

Dr. STEVENSON: Druggists, veterinarians. But for the people who are the problem to the police and to the authorities here in Vancouver, most of them have been in the category I have been mentioning.

Senator HOWDEN: Naturally, because they were unable to secure theirs, they hadn't the wealth to secure it without becoming entangled with the police. But the others may be, perhaps, just as dangerous to society generally—I mean to say as far as the others commencing the use of drugs.

Mr. LIEFF: Doctor, would you care to say why drug addiction is so common in British Columbia?

Dr. STEVENSON: Well, that is one of the projects we are supposed to be studying because the over-all objective of our University research is entitled "Factors Contributing to Drug Addiction in British Columbia".

Senator HORNER: You say you have them from all Provinces in the rest of Canada here—is that not true?

Dr. STEVENSON: I will give you some figures on that if you would like to have those too.

Senator HORNER: I would.

Dr. STEVENSON: And here again I think we can take it for granted that drug addiction has a high incidence in British Columbia. That doesn't have to be proven here—you've had figures given to you, I think.

Senator KING: Is that for later years, doctor?

Senator McKEEN: One Eastern paper had it 25% which, of course, is just ridiculous.

Senator HODGES: It's a greater proportion than that, isn't it?

Dr. STEVENSON: Well, the figures which you were given in Ottawa, I think, indicated that something out of the twenty-three hundred criminal addicts, so called, eleven hundred of them, or more are in British Columbia.

Senator McKEEN: They took the total population—25 per cent of the total population.

Dr. STEVENSON: Well, those figures you have been given, I have no comment on them of course, but we do know from the convictions, under the Opium and Narcotics Drug Act in each of the Provinces, we have those figures officially from Ottawa, for the last eleven years, and British Columbia has had the highest percentage of convictions, that is, with eight and one-half per cent of the population of Canada, British Columbia some years has had over 68 per cent of all the drug convictions in Canada. Yet that was the high point in 1952, because the percentage was a little lower in 1953 and lower still in 1954, but it's still more than half of the convictions under the Opium and Narcotics Drug Act of Canada that are made in British Columbia. For the first time, for these eleven years, the actual number of persons convicted under the Opium

and Narcotic Drug Act in British Columbia showed a decline—figures dropped from a total of 265 in 1953, to 192 in 1954.

Another figure that will give you some idea of the number we are seeing—drug addicts are being convicted in British Columbia of offences under the Drugs Act and of all other offences because more than half of them come into Oakalla because of convictions because of other offences than drugs; that is, vagrancy, forgery, breaking and entering, and so on. But they're coming into Oakalla at the rate of 450 convictions a year.

There are two or three misconceptions, I think they are misconceptions, but perhaps I am wrong; but, one, I have already mentioned in the first statement, that it is not due to high pressure salesmen and I dealt on that one. Secondly, I don't think it's due largely to migration from other Provinces because more than 75 per cent of the addicts we have studied began their addiction in British Columbia. And we are studying these in groups of one hundred each and in the second hundred and we're up to—we haven't quite finished the third hundred—but in the second hundred 82 of that hundred started their addiction in this Province.

Senator HODGES: Doctor, could I interrupt at this point, Mr. Chairman. You say that it isn't due to high pressure salesmanship. Doesn't that rather contradict the assumption which is generally taken that it is the profit in the business which causes the growth of drug addiction?

Dr. STEVENSON: Well, the people that sell—I think to be fair with them—are more concerned with selling to the addicted users than they are to getting new customers.

Senator HODGES: That is your experience, is it?

Dr. STEVENSON: Yes. It is the rarest thing to find an addict who will say that he started any other way than by chumming around with other addicts.

Senator TURGEON: Doctor, while we are on that point, I might say you have me worried. First, the large percentage of addiction that's in the United States, compared to the rest of Canada—I mean in British Columbia, compared to the rest of Canada. Secondly, the fundamental cause which is delinquency in the home, or early association; and third, the fact that it is not due to salesmanship. Now, does that mean that in British Columbia we have generally speaking a lower grade of bringing up of childhood? If those three things are correct it must be.

Dr. STEVENSON: No, no, I would disagree, Mr. Senator. I will explain that though if you would like me to.

Senator TURGEON: I would like you to. I am, frankly, worried.

Dr. STEVENSON: Now, I wouldn't say that at all.

Senator TURGEON: That would be the impression taken from that statement; the three statements together.

Dr. STEVENSON: I am giving statements now that it's things that drug addiction in B.C. is not due to, and then I'll say what I think it is due to in my judgment.

It is not due essentially to migration from other Provinces because 82 of this 100 started their addiction here. Third, it is not due, in my opinion, to Vancouver being a seaport town. A lot of people have suggested to me that this might explain it, but when one thinks that in the four Maritime Provinces at the eastern side of Canada, there are no convictions to speak of at all, I think that rules out that particular argument.

Senator HORNER: Might I just say though, that do the ships from the Orient not call as often—

Dr. STEVENSON: Next point is it not due to the proximity to the Orient, in my judgment, either, as most—this is what I am told by addicts themselves,

as well as by the police—that most of British Columbia drugs come from Eastern Canada via New York and largely originated in Europe. A certain amount of these drugs have come from Mexico and some have come from the Orient. I have no idea how much, I dare say that the R.C.M.P. and the city's narcotics people can give more information on that than I can.

Then, some of the points that perhaps might account—or account in part—for the high drug addiction incidents in B.C., and the first of these points is what is said to be the easy availability of drugs in Vancouver. Drugs are said to be easier to get here. We asked this question of any of the addicts that we interview, who have bought drugs in eastern Canadian cities and most of them say that it is easier to get drugs in Vancouver than other cities, but some say once you know your way around in Toronto, Montreal, Winnipeg, that they can get them just as easy when they know the ropes there as they can here.

Senator HOWDEN: Dr. Stevenson, there did appear in a recent number of the Readers Digest an article which purported to say that at the present time China was financing its war through the sale of narcotics. That at the close of the last war they were manufacturing about twelve hundred tons a year and that the quantity had gone up from twelve hundred tons to six thousand tons a year. It also stated that that amount of narcotics was being dumped on the American market. I am just telling you about the article.

Dr. STEVENSON: Thank you, sir. That could be quite so, but I have no knowledge of that and I am going—you see, we are also dealing with people who from time to time have been engaged in selling and they have been very frank with us, we've had very cordial relations with these three hundred addicts, most of them, and it's their opinion too that the drugs they sell come largely from eastern Canada. Now, whether it comes from China and gets into Europe and is converted into heroin in Europe and then comes, I can't answer that question. I just don't know the answer to that, sir.

Another feature which may account in part—I think each of these is just in part—is the historical tradition of the West Coast. The West Coast has a large number of Orientals here in the last Century; the United States brought out a great many to work on the railroads and they stayed, and the C.P.R. brought out Orientals and probably they stayed. And they were allowed in the early days to use their opium without hindrance and from them the white people started to use opium and consequently certain drugs of the opium drugs have had fairly common use on the West Coast for a great many years. And the figures which you were given in Ottawa by the Commissioner of the Mounted Police, as far back even as thirty years ago, that there were twice as many convictions for opium in Canada than as there are today.

Senator HODGES: Doctor, in that connection, you don't find many Chinese in the narcotic trade here now, do you?

Dr. STEVENSON: Not in the trafficking, no.

Senator HODGES: No. Do you find it in the addiction?

Dr. STEVENSON: There are a few. We're seeing a few, about four persons—

Senator HODGES: A very small proportion.

Dr. STEVENSON: Yes.

Senator HODGES: Practically died out?

Dr. STEVENSON: Yes. And they are the older people—

Senator HODGES: Yes.

Senator KING: Opium at that time was really the raw opium that they smoked.

Dr. STEVENSON: They smoked the opium, yes.

The CHAIRMAN: They wouldn't be using the heroin?

Dr. STEVENSON: No. Heroin is comparatively recent. We have another—

Senator BEAUBIEN: Doctor, with regard to these people that you interviewed, how many started to be addicts by starting to peddle the drug first—peddlers or “pushers” as you call them? Are there any percentages of those people who became drug addicts and were convicted?

Dr. STEVENSON: No. These three hundred people are all addicts and some of them have sold drugs since they became addicts, but I don't think any of them sold drugs before they became addicts. At least I have no knowledge of it if they did.

The next point about British Columbia is that British Columbia is a very large Province geographically, but a small Province in population with this very large city of Vancouver, I think it's the third largest in Canada, is it not? But because of so many frontier areas in British Columbia, the transient work, huge industries started, logging, mines, and such, all these hinterland activities attract a large population, there's been a large influx of people entering this province, and many of them have been hardy pioneer stock—the great majority doubtless have. But any frontier country attracts the adventurer and the get-rich-quick, the same as San Francisco was so well noted when it was in a somewhat similar stage of its development. And I think perhaps that answers the question that you wanted to raise, one of you, a few minutes ago, that there is, perhaps, a higher proportion of transient, unsettled, get-rich-quick element in this Province than might otherwise be expected, but as the Mayor said this morning it is still a very young province.

There is another feature which I hesitate to mention because I have been criticized when I mentioned it before, by one or two people, the fact that this is a new province and has a large number of new settlers, new citizens, and a large part of them that are a floating population, that British Columbia also has a very high incidence of a number of other conditions which may or may not be related to drug addiction. That is, there may or may not be some common factors and I don't see why these shouldn't be mentioned. They were mentioned in the press long before I mentioned them, by the Ottawa correspondent of one of the local papers. I think that's where I got the idea. That British Columbia has the highest alcoholism rate of any of the provinces. And I think we should keep in mind that alcohol can be a narcotic drug too. So that, in two narcotic drugs, heroin and alcohol, British Columbia presumably takes the lead.

Mr. LIEFF: I don't want to ask you this, doctor, with respect to any other figures which you may have, but with respect to that one point, where do you get your figures?

Dr. STEVENSON: This figure is given from the report of the Ontario Alcoholism Foundation which is a public document. Any of the figures given here are given from either government documents or published documents of other bodies.

Juvenile delinquency is reported by the R.C.M.P. report as being a very high rating, if not the highest in Canada. Indictable offences—convictions for indictable offences—is very high in the province in relationship to the population—perhaps the highest in Canada. The illegitimacy rate is the highest in Canada—up 6 per cent of the living births compared with about 4.5% of the living birth national average elsewhere. Divorce has the highest rating in Canada. Venereal disease is one of the highest rates in Canada, and suicide is at least twice as high in British Columbia as the national average.

The CHAIRMAN: That is quite an indignity.

Senator HORNER: You've got a high bridge!

Dr. STEVENSON: Well, I admit those are very challenging figures and I am not trying to prove anything by them, but one of our studies is, I think, is to try to find out if there is a relationship between those and the high narcotic usage.

Senator HOWDEN: Dr. Stevenson, this city is still a pioneer frontier—a pioneer city—and there is always a very large proportion of adventurers in pioneer communities and I think that that perhaps explains some of the preponderance of, shall I say, illegal proceedings—?

Dr. STEVENSON: I'm not saying what it's due to—I don't know.

Senator HOWDEN: In all pioneer places there are a lot of adventurers', and those are the people who would go in for morphine.

Mr. LIEFF: I suppose, doctor, you're just pointing these out as being symptoms of something.

Dr. STEVENSON: Symptoms of something. Whether it's something in the circumstances of life in British Columbia, or whether it's due to a higher proportion of unstable people, as I mentioned earlier, we haven't got that analyzed yet. But the facts are there.

Mr. LIEFF: I suppose that when we add drug addiction to that list we can bulk them all as being symptoms of something wrong with society somewhere.

Senator HORNER: Those figures that you gave will be chiefly Vancouver; Vancouver will account for the chief increase—Vancouver city alone.

Dr. STEVENSON: I haven't got the figures for Vancouver alone. These are given for the whole province.

Senator LEGER: Most of the addicts, you'd get them from Vancouver and maybe Victoria as well.

Dr. STEVENSON: Yes. The addicts themselves are largely Vancouver convictions.

The last point of a general nature there is that Vancouver has established in it now what might almost be called a colony of addicts, or cult of addicts. This large number that you've heard about, and the point that I think is of significance there, is that once you get a large group established, that people move in to supply them with their drugs so that buyers bring sellers and sellers bring buyers.

Senator LEGER: Mr. Chairman, at this point, may I ask a question? Do they all live more in one section of the city or are they spread?

Dr. STEVENSON: Yes, they do. We did a map quite recently on that, our social worker, Mr. Trasov, prepared a very interesting map showing the census areas and they're all, the police can tell you—at least the great majority—within a very small circumscribed area in the City of Vancouver.

Those are my general comments, Mr. Chairman.

Senator KING: Doctor, you spoke of the characteristics and kind of people that become addicted to drugs. Now, we have men and people working in lumber and mining camps and other industries. Do they feed into the city here largely?

Dr. STEVENSON: Yes. I'm glad you brought that point up. Many of these men are loggers, and miners, some fishermen, some construction people—

Senator HODGES: When you are speaking of many—you mean among the addicts?

Dr. STEVENSON: Among the addicts, yes. And they do come back to Vancouver in between jobs, or when they are laid off, or if the job folds up, they come back to Vancouver and commonly rejoin their friends that they associated with before they went. But the point I would like to emphasize is

that there are some of these people who formerly came down to Vancouver, or whatever city they might go to for, perhaps, a holiday and a spree on alcohol—some of them now come down for a spree on heroin.

Mr. LIEFF: They come down with a pretty good supply of money.

Dr. STEVENSON: That is right.

Senator HORNER: Is it possible, doctor, for a man, a woodsman or a miner, to do that—to go without it, come down here and have a “spree” as you say, and then go back to the woods and work without it?

Dr. STEVENSON: Yes. If he isn't off too long: That's being done right along.

Senator KING: They come in and have a spree.

Senator LEGER: How long would that be?

Dr. STEVENSON: Some of them are down here a month or two. They don't take it heavy, you see. They come down for a short time and they start with small doses—what they call “joy popping”.

Senator HORNER: They wouldn't need to if they were taking it all the year round—they wouldn't need to take light ones.

Dr. STEVENSON: No.

Senator HODGES: You call them addicts whether they're regular addicts or spasmodic—?

Dr. STEVENSON: Not necessarily. I think an addict should be a person who is physically dependent on drugs, but they are drug users nevertheless.

Senator HODGES: You don't include these people among what you call the addicts?

Dr. STEVENSON: Well, yes. They're using narcotic drugs.

Senator HODGES: Yes.

Senator BEAUBIEN: Do you find many of those loggers, etc., who go away for so long and then come back here? Do you have many of them in this prison of that type?

Dr. STEVENSON: There are a fair number of them that have worked as loggers and as construction workers in other parts of the Province for varying lengths of time.

Senator TURGEON: Would the percentage, doctor, of these outside workers you mentioned, loggers and miners, etc., be equal, greater, or smaller than the general percentage of British Columbia compared to the rest of Canada? That is the percentage of those compared of the number in British Columbia.

Dr. STEVENSON: I don't think I can answer that question.

The CHAIRMAN: Your statement is rather interesting, doctor. Frankly, to me it is a new statement to me entirely that a man could take drugs, come down here for a joy trip and go back up to a camp and work.

Senator HOWDEN: It's very easy to understand because when a man goes back to where he has to work desperately hard, that takes the place of the narcotic. When night comes, he's dead tired and he goes to bed and sleeps and in the morning he goes to work and he hasn't got a chance to think about narcotics.

Mr. LIEFF: Doctor, that brings me to another question. I wonder if you would care to deal with it at this time, it is this: What are the harmful effects of narcotic drugs on, first of all, the individual, and secondly on society which results from taking drugs. Would you care to deal with that?

Dr. STEVENSON: This has been a very challenging and difficult problem for us because the general opinion has been that the taking of drugs is exceedingly harmful on the individual who takes them, and hard on society too, and when I came to undertake this study I thought we would have no difficulty

in finding a scientific study of the harmful effects of narcotic drugs. To my amazement we haven't been able to find any. It's the rarest thing to find—in fact we haven't found one—real scientific study on the harmful effects of narcotic drugs. People have their opinions and general ideas, but to ask them to prove them, or to give you data for them, we just haven't been able to get them.

Senator McKEEN: There is one point you mentioned awhile ago addictions were less in 1954 than 1953. Have you any reason why they were less last year.

Dr. STEVENSON: No, I haven't thought that one through, and I haven't enough data to answer that, sir.

Senator McKEEN: But there was a substantial drop apparently last year over the year previously, so something apparently is being done. I don't suppose it just happened that way.

Dr. STEVENSON: That was the first time there had been a drop in the total number of convictions for eleven years.

The CHAIRMAN: Could one infer then, doctor, that the life of the drug addict is not affected; does he live as long as the other individual? You say there is no harmful effect.

Dr. STEVENSON: Well, I just haven't said that yet, Mr. Chairman. Oh no, there are harmful effects, very definitely harmful effects, but the general concept of the effects haven't been proved scientifically. That is the point I want to make clear. We've been searching for scientific studies and haven't found any. And extreme claims that drugs ruin a person's body, mind and soul, we haven't been able to find scientific evidence to support that statement. This does not mean that there are not harmful effects, we know that there are, but they haven't been studied scientifically and recorded, and that is one of the studies we are attempting to make in our three year study.

Senator McKEEN: Doctor, of all these related things you mentioned about this delinquency, and immorality and everything else happens to be related to drugs, I would think there was a very decided bad effect to your individual who is taking drugs.

Dr. STEVENSON: But you will remember what I said though, that 75% of them were in crime before they went on drugs.

Senator TURGEON: That's the point that worried me.

Dr. STEVENSON: That's the point that has to be emphasized.

The CHAIRMAN: Tell me this, doctor, in your examination, if 75% of the criminals' morals are all gone, will the stories and statements they make be on the high level of honesty. I'm just thinking of a man who has lived a life of crime and who had been lying all his days, and putting it over on the police and putting it over on everybody all his life, then when he comes before you does he come as an honest citizen and tell you all the truth?

Dr. STEVENSON: He tells us the truth—I'm satisfied we're getting the truth in a general way from these people. I'm giving you the information as we receive it and believe it. It doesn't mean we believe everything we're told any more than you would believe everything you're told, Mr. Chairman, but the data, for example, about the convictions, that's all taken from the official records. We know, for example, that 75% of these people were convicted and in delinquency before they went on drugs. We know that from the records, not because they tell us that.

May I go on with this? I think this will enlarge on what you had in mind, perhaps.

The CHAIRMAN: Yes.

Dr. STEVENSON: Moreover, heroin and morphine in small doses are sedatives and pain relievers and—

Senator HOWDEN: Anesthetics.

Dr. STEVENSON: Yes, analgesics. And they do not stimulate a person to crime or violence in small doses. We get them in hospital ourselves and we're not affected that way. And the heroin addict too, even when he's taking drugs heavily is not converted into a "dope fiend", that is, he isn't a frenzied, wild person going out to do harm to people. Nor do large doses of narcotics of the heroin type stimulate him to crimes of violence. Rather they tend to keep him quiet and subdued while the drug is in him.

Now, there are, as I indicated, certain harmful effects as a result of taking drugs, but I would like to discuss these in a physical, mental and moral field. The physical effects of narcotic drugs, the greatest danger appears to be death from over-dose. Also, there is the risk of infection from unsterile hypodermic needles, they become chronically constipated, there is a reduction in their sex urges and desires because of the sedative effect of the drug—those are what you might call direct effects of taking heroin.

The indirect physical effects are poor hygiene due to neglect of their care, self-care, they lose weight due to their loss of appetite and their neglect of proper diet, their teeth become bad for the same reasons—don't get proper food and vitamins—but the continued use of heroin, so far as we know here, from the studies I have made, does not produce perceptible brain damage, or liver damage, as alcohol addiction may do, along with other things, or any other marked, appreciable physical damage.

Now the mental features. There being no perceptible brain change from taking heroin, the intelligence is not injured. We have recently studied a man who has been on drugs for thirty-five years who has an intelligence quotient of 135 still, whatever it may have been thirty years ago. These drugs are toxic agents nevertheless and, like alcohol, depending upon the amount in the circulation of the blood and in the brain, and so on, may interfere with his judgment, produce an artificial state of elation, may produce a feeling of indifference to proper standards of behaviour, and may slightly impair mechanical skills. I am not satisfied, however, that long continued use of narcotics produces of itself an appreciable personality change.

Senator HOWDEN: How about hallucinations?

Dr. STEVENSON: They never have hallucinations.

Senator HOWDEN: Or illusions?

Dr. STEVENSON: No, not from heroin. When they're having withdrawal symptoms, when they're getting it out of their system, they can be very sick then, but even then I have never seen one that was really hallucinated. Cocaine will produce hallucinations of course, but heroin and morphine in drug addiction quantities do not produce delusions or hallucinations.

Senator HOWDEN: Well, Chinese laborer, home in China where he smokes opium pipes all the time, that partially sustains him. He is very poorly fed and he works pretty hard but he must have his opium pipe in order to do so. And I have read that they were mentally comforted and saw things mentally in quite an illusion type, so to speak.

Dr. STEVENSON: Well, I know what you mean, I think, and in De Quincey's book, "Confessions of an English Opium Eater", he speaks of his reveries; whether they were true hallucinations I think is very doubtful. My reading of the opium smoking in China doesn't bring out true hallucination. The feeling of comfort you have spoken of, a person can have a pleasant reverie, but that is about as far as they'll go. Not to the stage of true hallucinations.

Mr. LIEFF: Cocaine, of course, is not the drug of addiction at the moment?

Dr. STEVENSON: Cocaine is used very rarely in British Columbia.

Mr. LIEFF: Yes. Thank you, I see.

Dr. STEVENSON: The moral character—what are the effects of heroin addiction on the moral character of an individual? The common assumption that narcotics ruin a person's moral character by changing him from a highly moral to a grossly immoral person also lacks substantiation in our studies. When one realizes that the criminal addicts, so-called (I don't like to use that word, that phrase) that we studied at Okalla, were practically all immoral or delinquent or alcoholic before they started on drugs. And they continue in these ways after becoming drug users, one is not able to see that moral character has been appreciably altered. Moreover, there are records of some people who could get drugs legally in various ways, various countries, who are able to afford them, and their moral character has not been questioned after they went on drugs. I won't take time to give you the names of some of these people but they are very well known to you—some pretty historical figures.

Senator HOWDEN: They were addicts?

Dr. STEVENSON: They were addicts. Jean Cocteau recently elected to the French Academy—one of his books on opium addiction is his own autobiography. Falstead, the very famous American surgeon, was a cocaine addict—later he was one of that country's most famous surgeons. And neither of these people, as far as I have any knowledge of, were immoral or delinquent, or anything of that sort.

However, narcotics do have harmful effects on the addict, both directly and indirectly.

Directly: The first one that I'd like to mention is that the addict by becoming completely dependent on the drug thereby has to put drugs in first place in his life. They become not just an adjunct to living, but they become life itself to the addict and everything else has to take second place. This is socially undesirable and must interfere with the best possible achievements of the individual.

Another harmful affect, there is very little margin of safety between the casual, or social use of narcotics and narcotic addiction. Few people starting on drugs expect to become addicted, but they soon find that the habit is out of control. Alcohol, on the other hand, offers a fairly wide margin of safety between social drinking and alcohol addiction. It has been said that one has to work hard at drinking for several years to become an alcohol addict, whereas drug addiction sneaks up on you quickly before you realize it is there.

The third harmful effect I'd like to mention is the craving for the drug when feeling the need for it and the enjoyment the addict gets out of it when he's using it, and providing he cannot get his drugs within his means, will exert a strong influence on the addict to get money for it by illegal means. However, the addicts we see in Vancouver were very largely delinquent, immoral or alcoholic before starting on drugs. So drugs have not started them on delinquency and these other things so much as that they have increased their delinquency. They steal more than they previously stole; the women engage more in prostitution—they engage now as professionals rather than as amateurs previously—and drugs keep both these groups of men and women in delinquency. That is, there is no hope of them giving up their delinquency as long as they remain on drugs. There is another deleterious or harmful effect, and that is on the addicts' employment record. Even if he has a steady job when he starts on drugs, the increasing dosage soon takes more money than he can earn legitimately. He may therefore give up his job—his legitimate job—to have sufficient time for the illegal search for funds. Moreover, even if he keeps his habit small, as many addicts do, and within his legitimate income, he still has to take several fixes a day. "Fix", as you know, is the

term for a shot or drug. If he has drugs in his system he is apt to be indolent, careless, late for work, absent from work, and an indifferent workman. And then, at the same time, when the effect wears off, when he feels the abstinence symptoms beginning, the restlessness and the gastric disturbance, agitation, then he will be less efficient at his work in that stage too, he will have to absent himself from work to give himself a shot and in all these ways his work history suffers. He loses the confidence of his employer and they soon find that his services are no longer required.

Now, those, I consider are the direct harmful effects of narcotics on the addict—on himself.

There are also indirect harmful effects of addiction on the addict. First of all he becomes an object of fear and scorn and suspicion on the part of the general public. Secondly, an employer won't hire known drug addicts, even if they're not using it at the time, or rarely, because they are afraid of them relapsing and afraid of them returning to crime. Third, they are constantly being questioned and checked by the police if they are in a large city, whether they're using drugs or whether they're not using them. It is the duty of the police being carried out, but they are constantly being under surveillance.

Fourth, if they are using drugs, they are almost certain to be constantly in crime and inevitably get sent to jail, with all the disrupting effects that being sent to jail may have on them personally, and their family relationships and in their employment record. Addiction also has some harmful effects on society generally; first, chiefly the economical loss to society through the depredations of addicts to get funds to buy their drugs. And in this cost should be included not only what they steal but the cost of the courts, the cost of the police, the cost of their care in prison. Secondly, perhaps still with the economic factor, it might be mentioned that the women addicts are largely prostitutes. They get their funds illegally it's true, but they are donated to them by their clients.

The second harmful effect on society is the fact that the addicts are in the community probably does influence some young people as they themselves were influenced to follow in the footsteps of addicts. That's the fact that they're there may influence the starting of other people on addiction.

And the third harmful effect on society, the addict prostitutes and prostitutes generally, are one of the chief means of spreading venereal diseases. It is estimated that about half, or more, of the prostitutes in Vancouver are drug addicts. Non-addicted prostitutes are not infrequently alcoholics but because their expenses are less they don't run the risk of infecting as many customers as the addicted prostitute does.

Senator TURGEON: In a rough estimate, doctor, what of the percentage between men and women addicts?

Dr. STEVENSON: Three men to one woman. Almost exactly according to our figures.

Senator HODGES: Mr. Chairman, time is getting on I imagine. I hope we are going to have an opportunity of hearing Dr. Stevenson say something about the suggestion which is often being made on the establishment of narcotic clinics?

Mr. LIEFF: Senators, I was just going to ask the following question of the doctor. I was going to ask what treatment plan you recommend for addicts?

Senator HODGES: Yes, I am very anxious to hear that. It has been suggested from various sources that if we had narcotic clinics where drug addicts could get their drugs either free or for very low cost and thus do away with the profit motive, that we would almost wipe out drug addiction. I'd like to hear the Doctor's views. I know he has pronounced views on the subject.

Senator HOWDEN: I think there is a question preceding those questions that might well be asked. That is, Doctor Stevenson, have you any record of cured addicts?

Dr. STEVENSON: Oh, yes.

Senator HOWDEN: Definitely?

Dr. STEVENSON: Oh, unquestionably. But I would like to discuss the concepts of "cure" as a part of my presentation.

Senator HOWDEN: Yes. Well that, I think, is the all-important matter.

Dr. STEVENSON: Oh, yes.

Mr. LIEFF: Mr. Chairman—with your permission Dr. Stevenson—I have three questions to ask, one of them is the one I just asked—

The CHAIRMAN: Just a minute, please. I wonder, Senator Hodges, if we could leave your question and bring it up under a new subject so that we could go into it fully, because—

Senator HODGES: Well, I was only thinking of the time. I didn't know how long Dr. Stevenson was going to be here.

The CHAIRMAN: He'll be here this afternoon.

Senator HODGES: Oh, I beg your pardon. I didn't know Doctor was coming here this afternoon. Oh, I'm sorry. The agenda has been altered likely—

The CHAIRMAN: I'd like to review that the—

Senator HODGES: I say, the agenda has been altered.

The CHAIRMAN: A little bit.

Senator HODGES: Oh, well, we prefer the question then, Doctor.

Dr. STEVENSON: Thank you.

Mr. LIEFF: I just wanted to ask what you had in mind for a treatment plan, whether you had any recommendations to make with respect to a treatment plan for addicts, doctor.

Senator HOWDEN: That should be the very end—the finish.

The CHAIRMAN: That is a very important subject.

Senator HODGES: Mr. Chairman, may I interject a comment here? May we be told of the change in the agenda then? Because I was simply going by the agenda that we have before us.

The CHAIRMAN: You have four names before you for Monday.

Senator HODGES: Yes.

The CHAIRMAN: Captain Leslie, Salvation Army; Doctor Ross MacLean, Vancouver Physician; Mr. R. S. S. Wilson—

Senator HODGES: Well, are they all speaking this afternoon as well as the Doctor?

The CHAIRMAN: Mr. Wilson is off and Magistrate Orr is on. That's the only change.

Senator HODGES: Oh, I see. But Doctor Stevenson is going on this afternoon.

Senator TURGEON: Dr. Stevenson will be on after two o'clock also.

Senator HODGES: Oh, well, that's the point I wanted to make.

The CHAIRMAN: We are not putting any time limit—

Senator HODGES: I just wanted to make sure. Sorry, Doctor.

The CHAIRMAN: Go ahead.

Senator HORNER: What is the question again?

Mr. LIEFF: The question is what treatment plan do you recommend for addicts?

The CHAIRMAN: We'll defer that because there are one or two questions which should be asked probably dealing with the last matter that we touched on. We'll come to the treatment plan and we'll then deal with the statements made in his bulletin about the British system and the suggestion by the clinic that free drugs be given. That is a subject we are all interested in.

Mr. LIEFF: There is another question, of course. What about the legal sale of drugs and any other suggestions you might have doctor. It has been suggested that we perhaps take them in slightly different order. What you have in mind yourself I don't know.

Dr. STEVENSON: I just have two more subjects, or facets of the problem that I would like to discuss. One has to do with the whole problem of treatment and the other one has to do with additional points having to do with control of the narcotics.

Senator HODGES: I would like to move that the Doctor go ahead then with his presentation.

Dr. STEVENSON: This is a longer statement and I'm afraid you're getting tired of listening to me here.

Several Senators: No, no, go ahead.

Dr. STEVENSON: This section of the discussion then, has to do with treatment for drug addicts. I would just like to preface that by saying that as a physician and my approach to the treatment is, of course, the treatment of the individual. At the same time I am aware that there are number of other aspects of treatment and control which other people will perhaps present to you differently than I will deal with the subject.

The needs for better methods of treatment, better control of the whole narcotic problem, was uppermost in the minds of the Vancouver Community Chest committee, as well as the University Advisory Committee which organized this research which I have the honor of directing.

The known high relapse rate, with all previous forms of treatment, even in so excellent a hospital as the Lexington Hospital. You know about the Lexington Hospital?

The CHAIRMAN: I have heard of it.

Dr. STEVENSON: It is operated by the United States Public Health Service, in Lexington, Kentucky, and is almost entirely for the treatment of narcotic addicts.

The need for treatment has had a great deal of thought with all of us. It was recognized that getting the person off drugs is relatively easy. The problem is how to keep them off them—how to prevent them relapsing and what can be done to prevent relapsing. First of all it should be kept in mind all the forces which directed him towards drugs in the first place. Inherited instability, poor training, personality weakness, association with addicts, strong desires for sensory pleasures; unwillingness to accept social responsibility, easy discouragement—all had continued to exert their influence to push him back to drug usage. A drug which, for the time, seems to solve all his problems. Even a heavy alcohol use does the same for many persons who are addicted to alcohol. That is, the forces which led him to take drugs the first time lead him back to it again and again, reinforced now by his pleasant memories of what it did for him previously.

The object of treatment, therefore, after realizing that the addict is a victim of his inheritance and faulty training and personality weakness, and poor habit formation, the object of treatment is to take such assets as he still has, (as one does, say, for the blind or an amputation case), take his assets and train him for social adjustment. Psychotherapy may give him a better understanding of himself and why he takes drugs. But he needs much more

than understanding. He needs training and retraining. He needs emotional maturing. He needs social acceptance. He needs occupational opportunity and he needs to give up his delinquent associates and his delinquent way of life.

It should be made clear too that there is no magical cures of drugs even in this age of miracle drugs, such as antabuse, for example, for the alcoholic addict. That is a chemical substance which makes it impossible for the alcoholic to drink without becoming deathly sick. We don't have such a drug to counteract heroin. At the same time, researchers should be constantly looking for a drug which, on the one hand might kill the desire for narcotics, or on the other give them sufficiently comforting effects without producing addiction or other socially or medically undesirable effects.

The concept of cure for addiction should be a modest one, increasing the personality strength and social adjustment of the addict on the one hand and providing him with an environment in which he can work and live with reasonable happiness and without having recourse to unfavorable habits. That is just a social cure that I'm talking about, not a clinical cure, not a surgical cure, such as removal of an inflamed appendix, but a social restoration with the ability to control socially unsatisfactory forms of behavior. That is what I mean by a cure. A person can't be cured of the desire for wanting drugs any more than those who don't smoke are cured of the desire to smoke. Some of us have given it up but would like to smoke right now. But when we don't smoke we're not cured.

When I came to Vancouver in November, 1953, I soon learned of the large size of the addiction problem, but I also learned that there were no treatment facilities available to the average addict, many of whom came to me asking for treatment and many more left Okalla and British Columbia penitentiary only to relapse to drug use soon after leaving.

As I have indicated, the Chest's committee on addiction, University Committee, were also much interested in the treatment centre. I approached the authorities at the Crease Clinic at the Essondale Hospital and was informed that they did not see their way clear to receive addicts for treatment. I approached the Vancouver General Hospital and was told that they could not receive addicts even for withdrawal treatment because the British Columbia Hospital Insurance Plan would not pay them for the hospitalization of such persons. A private sanatorium which I approached was willing to accept addicts but the costs were so high that ordinary addicts could not afford it. Even small private hospitals were reluctant to take addicts and their fees were also higher than could ordinarily be paid. So, there was no treatment facilities, as such, available, in spite of the fact that there were so many addicts in British Columbia, many of them asking for help.

Treatment for addicts falls naturally into two phases. A: the withdrawal treatment, and B: convalescence and rehabilitation. In the withdrawal phase the patient is very sick physically and mentally. He needs good medical and nursing care; he needs total security because of his not infrequent suicidal attempts, and his tremendous craving to seek out drugs. He needs security to be isolated from his well-meaning but misguided friends who might bring drugs to him.

Senator HODGES: Excuse me, doctor. When you say "total security" do you mean segregation?

Dr. STEVENSON: Yes. Such as the psychiatric ward at the Vancouver General, or at Crease Clinic where one is behind bars or locked doors, if you like, where he can be protected from himself and protected from his misguided friends.

There are various methods of helping a patient through this withdrawal period. Usually the patient is over the physical suffering in five to fifteen days and is ready then for the convalescence and rehabilitation period. For what

I considered good reasons, I recommended that the rehabilitation treatment be taken in a centre completely separate from where the withdrawal treatment would be taken. I recommended, too, that the British Columbia Government be asked to change the regulations of the Insurance Act to permit General Hospital to be paid for withdrawal treatment of addicts for a period not exceeding three weeks. Even if this request is approved, and I haven't learned yet whether the Government has taken any action on it, the General Hospital, because of their over-crowding, may still find it difficult to take addicts for withdrawal treatment. I have also urged, therefore, that pressure be kept on the Crease Clinic, or Essondale, to give withdrawal treatments there, and if financial arrangements can be made, that the private sanatorium previously referred to, or other private hospitals, might also assist with the withdrawal treatment.

I should state here that because many addicts have "kicked" their habit—I don't want to bring slang into this, but this is the phrase these use for curing themselves, or getting off drugs themselves, kicking their habit—with very little help and have gone to work immediately and without relapse for months or years, even permanently, and because long incarceration either in prison or hospital is no guarantee against immediate relapse I see little reason to commend the idea of a long and enforced incarceration in a narcotics hospital of the Lexington type.

The Lexington Hospital, excellent as it is in every way, readily admits that its high percentage of relapses is in part because it lacks post-hospitalization rehabilitation facilities. I have therefore recommended that the addicts go direct from the place of his withdrawal treatments—General Hospital, Crease Clinic, private sanatorium—to the rehabilitation centre. My idea of a rehabilitation centre, having in mind that it would be a pilot plan and should not involve large capital outlay, was that a large rooming-house, or nursing home, or private hospital, be rented as a going concern, should have accommodation for fifteen to twenty men and be staffed by trained social workers and rehabilitation officers, with medical consultants and other consultants and assisting staffs. I recommended that patients admitted to it should come voluntarily; that the expenses be taken care of for a maximum of four months, during which time physical and mental convalescence would be aided by psychotherapy, by occupational therapy, recreational therapy, by companionship of volunteer workers and that a job be found for the person as soon as possible after he enters, within a month, the patient continuing to reside in the rehabilitation centre up to the four month maximum, if his job was within the metropolitan area of Vancouver.

On leaving the rehabilitation centre he would be expected to keep in touch with the centre, would report immediately any work lay-off or social difficulties, and would be free to return to the centre if he needed further help or if he returned to Vancouver from a distant part of the Province if he had gone there in search of work.

For women addicts who exist in a ratio to men of one woman to three men, I recommended foster home care with the same program of rehabilitation, but only one or two women in a foster home. They would be paid—the hostess, the mother in the home, would be paid for at a reasonable rate for the one or two women she would have. And the women would be visited every day by the social workers of the rehabilitation centre. Jobs would be found for them in the same way as for the men. Because of their previous immoral habits it seems undesirable that women should be living fifteen to twenty in one house as was recommended for the men.

The Community Chest committee accepted these proposals and incorporated them in briefs to the British Columbia Government. The Speech from the Throne in January, 1955, indicated that the Government agreed to offer assist-

ance, presumably along these lines, or some similar lines, and funds were voted for implementing these proposals. I have not heard yet if the Hospital Insurance regulations have been changed to permit payments to general hospital for withdrawal treatment.

It is expected that a citizens organization, something like the Alcoholism Foundation, will be set up to receive the government funds for the operation of the rehabilitation centre.

It should also be noted that addicts completing their sentences at Okalla, or the British Columbia Penitentiary, who will have had their withdrawal treatment in those institutions may be admitted to the rehabilitation centre after completing their sentence for rehabilitation.

I have already indicated that I do not favor compulsory detention for lengthy periods in a Lexington type institution in a remote area of the Province, such as has been advocated from time to time by others, notably the police. It is understandable that the police, knowing that addicted persons are usually involved in crime to get funds for this expensive habit, would wish to have such persons away from Vancouver and safely under lock and key and getting treatment in some remote place. It is also argued that addicts at large are like cases of open tuberculosis in that they influence or infect susceptible persons to join the ranks of the drug addict. I think that statement would be difficult to substantiate except very rarely.

From the standpoint of the individual addict it is a well known fact that long periods of incarceration, even in excellent hospitals such as Lexington, is no guarantee of abstinence from drugs on release. A great majority of addicts leaving prison revert to drugs immediately, or within a short time, if rehabilitation and employment facilities are not available. That's why we are emphasizing so strongly the need for rehabilitation facilities. Moreover, if treatment were compulsory the addict would resent the incarceration as he now does his imprisonment and would show this resentment by returning to drugs even if it means re-arrest and return to prison. It should be noted that the addict does not really fear prison and in contrast with the life he lives on the street as an addict he may be much happier in prison than out of it.

Senator HODGES: Doctor, may I interrupt there. Then why does he resent it, if he is happier in prison?

Dr. STEVENSON: He doesn't agree that he is happier. He still wants his freedom. At the same time, when one sees the addict in Oakalla, how quickly they improve under the good care they get there, they really are much better off than they are in some conditions the way they have to live on the street, going out from day to day to steal, and things of that sort. They all recognize that it is a rat race with just a dead end street.

The CHAIRMAN: Doctor, how do you separate the dual life the drug addict has? He is a criminal addict in the first instance, I am speaking of him. He is picked up for drug addiction. Now, would you say that a man who has lived a life of crime, and had been picked up for drug addiction, if you put him loose and put him on some kind of parole without anybody looking after him, would it cure his immoral life?

Dr. STEVENSON: No, I'm not—

The CHAIRMAN: You must differentiate.

Dr. STEVENSON: I'm saying that he should have after-care, that he should go to rehabilitation centre and should have follow-up for an indefinite period. But there are addicts on the streets today—a woman was in to see me last week with no charge against her at all—but she's an addict and she's pleading for help but there's no place I could send her.

Senator TURGEON: Could I interrupt for one further question. Would what you are just saying now in answer to the last question or two apply to the statement made previously that the addict becomes an addict largely because of his life not being a proper one and he is criminally inclined to some extent before he becomes an addict—then, after he's an addict, is he more criminally inclined than he was awhile ago?

Dr. STEVENSON: Only to steal oftener or larger amounts than he did before.

Senator TURGEON: The same person would be criminally inclined if he had never become an addict?

Dr. STEVENSON: Well, as I mentioned earlier, they have had convictions but that doesn't mean that those people are in crime all the time. They go years in between offences. A person may have only one offence and never again be in trouble with the police. There are many people, not only in Vancouver but every city, who had a conviction when they were young and then have straightened up and have kept out of trouble ever since. Some of these people could do the same.

I'm glad you brought up the point though. In any treatment planned I think it has to be quite clear that it is not just a matter of relieving him of his addiction but a matter that he has to change his whole way of life.

The general tendency to speed up and streamline hospitalization for most conditions these days might also be thought of as another reason for not assisting long, boring periods of relative inactivity in hospital, the high cost to the community for its upkeep and loss of potential wages. Most addicts do desire to be relieved of their affliction and the best results have been achieved when the addicts have had good work opportunities, good home life and absence from the drug-contaminated area of the city where he was formerly residing.

If an addict refuses to take treatment when offered to him, or fails to cooperate with the treatment program, then he should be regarded the same as any other person if he breaks the law and be treated accordingly. At the same time there is the occasional case who is benefited by compulsory treatment and it would be desirable to have provision made in the statutes of this Province and all Provinces for compulsory treatment where especially indicated as is provided for in four Provinces—the only one I have personal knowledge of is Ontario—where provision is made for the treatment of both alcoholic and addicts in the Ontario Mental hospitals.

A Lexington type maximum security hospital would be costly to maintain, might be very difficult to staff, especially if the Williams Head site should be selected, and although British Columbia has roughly half of Canada's addicts, I doubt if it wants the other half even in a maximum security hospital here. A maximum security hospital would still be a jail to the addicts. Moreover, the recommendation for compulsory treatment for long periods in a maximum security hospital only vaguely disguises the fact that the proponents of such a plan are greatly concerned with getting law-breakers away from areas where they have jurisdiction. Our society would be protected to some extent by the isolation of addict law-breakers. Their removal only leaves the field open to non-addiction law-breakers who, in Oakalla, out-number addicts by thirteen to one. Moreover, the same reason then would apply to the women prostitute addicts. Why segregate them even for years, or for life, as is recommended by some people, and leave the field to the non-addicted prostitutes. It should be noted, too, that female addicts do not ordinarily engage in theft but receive fees donated voluntarily by their friends. Many of the non-addicted prostitutes are alcoholics—that is, they are addicted to alcohol. Why discriminate against the heroin prostitute and favor the alcoholic prostitute. The same general comment applies to the men. We have studied an alcoholic bad check passer

who had been sentenced five times in the past year to Oakalla. Why don't we isolate him for a year in a similar hospital for alcoholics. Or, to be logical, why not isolate all repeating law-breakers?

I am not advocating any such plan, but use this argument to point up the essential unfairness of discriminating against the man who prefers heroin to alcohol.

It should be recognized that long term isolation has not worked well with alcoholics. It certainly hasn't worked well with drug addicts and it's only justification, if applied to addicts, is that it would take one segment of law-breakers off the street as a protection to society but leaves the field open to all the other recidivists.

The CHAIRMAN: Doctor, could I interrupt you right now. You haven't answered the question asked by Senator Hodges. I was wondering if we could adjourn for lunch now and come back at two o'clock?

Senator HODGES: And then resume his evidence.

The CHAIRMAN: I wonder if you would come with us and have lunch as a guest of the senators.

Dr. STEVENSON: Thank you very much. I have another appointment, I'm sorry.

The CHAIRMAN: We are adjourned until two o'clock.

The Committee adjourned until two o'clock this afternoon.

AFTERNOON SITTING

The Committee met at 2:00 p.m.

The CHAIRMAN: We will commence with Dr. Stevenson where he left off. He was going to deal, I think, with the free drug aspect.

Mr. LIEFF: You were dealing with suggestions about treatment at the adjournment. I was just wondering, doctor, if you had any other suggestions for a more satisfactory way of handling the drug addict than we are handling them now, in addition to what you have already said.

Dr. STEVENSON: Well, I have several other suggestions and in the course of these remarks I will have something to say about the legal sale. Unfortunately, I lost my glasses during lunch hour. I had to borrow these glasses.

In addition to the treatment features, then, that I outlined this morning, there are several other features that I would like to suggest for your consideration, and the first one is a repetition and emphasis on what I made this morning; namely, that maximum efforts to prevent drugs coming into Vancouver is tremendously important to prevent them becoming easily available to the addicts. The need for still greater concentration of police effort and total efforts against the trafficker and the smuggler, I think, are of paramount importance.

Then, the second one, for uncooperative addicts who refuse treatment for their addiction or repeatedly break the laws, I would suggest that we stop thinking of them as addicts and think of them as we think of law-breakers generally, and that they be treated the same as any non-addicted law-breaker.

Mr. LIEFF: Has anybody else got a pair of reading glasses?

Senators—several offers.

Senator HORNER: These are just an old pair of reading glasses.

Senator LEGER: These are just reading glasses, too.

Dr. STEVENSON: Lots of offers. That is swell. Senator Horner's glasses are satisfactory.

They should not be excused from the penalties the law provides merely on their claim that they steal to support their habits. Addicts don't steal to support their habits, they steal to support themselves and their expensive tendencies, and the habit can be broken by any addict fairly easily if he can be offered a better life or can develop a better value system.

Then a third general recommendation or suggestion is that anything that makes for better home life for children and adolescents is something that should be cultivated by all parts of the general public and better parents, better parent education, better working conditions, better attitudes to society, better mental hygiene training, better children and better education for life.

The next point is a point on public education which is also a controversial point, and I think it needs to be emphasized that both the doctors who become drug addicts and the underworld or delinquent people who become drug addicts, all have had education on drugs. The doctors have had it through their medical schools, and yet some of them have become drug addicts, and so have some nurses and others. And the so-called criminal addicts, or the under-privileged addicts they have learned all about drugs in the communities in which they are raised, and as they become adolescent their association with people who know about drugs, but it hasn't kept them away from drugs.

Mr. Anslinger, the Commissioner of Narcotics in the United States is strongly against public education of school children on drug addiction because he says it's apt to stir up their curiosity rather than appease it and he points out what I pointed out, that the people who become drug addicts have had plenty of education on the subject and still have gone on drugs.

Then,—perhaps I'd better leave my comments about legal sale until the end. The question of the laws which pertain to narcotics and to addiction, and I may be treading here on ground of which I am certainly not an authority, but the laws pertaining to narcotics have been scrutinized and were amended at the last Session, they perhaps might be scrutinized still further. We've—speaking for myself rather—I would like to point out that the opium and narcotics drug act as it stands now is a pretty harsh law as it relates to people illegally in possession of drugs. The minimum compulsory sentence is six months in jail. The magistrate or judge has no—is not allowed to exercise discretion, is not allowed to give suspended sentence or probation or fines, but he is required by the Act itself to impose a minimum of six months. We recently studied a girl who, at the age of fifteen, in Vancouver, was associating with people who were drug addicts and she had some drug too and was caught and convicted and sentenced to six months in jail. So that I am recommending that for first offences at least, there be—that the judge or magistrate have the power to use his judgment in the matter of probation or suspended sentence, possibly even a fine, rather than the compulsory jail sentence.

Senator HODGES: May I interrupt here, Mr. Chairman? Doctor, in connection with that, wouldn't you want to put in some proviso that they have treatment of some kind or would you just let them loose after finding them?

Dr. STEVENSON: Well, it depends there what the charge is. There are a large variety of charges. I am speaking here of the Opium and Narcotic Drugs Act. I think that is a very good point, Senator, and I would agree that if the patient, or prisoner, is given suspended sentence or something else, that one of the terms of it should be treatment.

Senator HODGES: Otherwise you have somebody—their first offence—when they are more amenable to treatment than rehabilitation.

Dr. STEVENSON: That's perfectly right. I'm glad you mentioned that.

Senator HORNER: Of course, the consideration could be taken as to what it would mean, perhaps a good home—

Dr. STEVENSON: Yes. Well, if these treatment facilities that I was speaking of this morning, were set up, such a person could go there. As a matter of fact that is the next recommendation I was going to make for persons who have been sentenced to say second or third, or even further, offenders, that is that they should be given the same parole privileges as other prisoners. At the present time, a person convicted under the Opium and Narcotics Drug Act is not entitled to parole. He must serve out his full sentence without any usual time off for good behaviour. And there, I was going to recommend that one condition of the parole in certain cases might be that the subject agree to accept treatment for his addiction in a rehabilitation centre. But that would apply to the point you made too, Senator.

Senators HODGES: In case of a first offender?

Dr. STEVENSON: Yes. I'm glad you mentioned that. I overlooked that.

I suggest too that the attitude of the law and society as expressed through the Opium and Narcotic Drugs Act, indicated that we have one law for the slum-born or under-privilege addict, socially handicapped addict and another for the professional addict. I am aware that it is not a crime to be an addict in Canada—it is a crime to be illegally in possession of certain narcotic drugs. While in effect the law, as applied to illegal possession, is directed at the man for being an addict because the only reason the non-pushing, non-selling addict has heroin in his possession is to enjoy its effects. During the past year I've seen this fifteen year old girl I referred to, also seen a fifty-five year old woman with only a few cents worth of heroin in her possession at drug store prices intending to take it for her own comfort, sentenced to five years in the penitentiary.

Senator HODGES: Had she a record, doctor?

Dr. STEVENSON: Yes, she had a record for which she had paid her penalty.

Senator HODGES: Yes, I know, but I mean—

Dr. STEVENSON: She had a record. She had been convicted before for the same thing.

Senator HODGES: Well, was she simply as an addict or a pusher?—

Dr. STEVENSON: No, just for simple possession. She wasn't doing anything else except giving herself this injection of heroin.

Senator LEGER: Was it bought illegally?

Dr. STEVENSON: It was brought illegally. She was in illegal possession.

I have also seen a man with a job to go to the next day, would come down to Vancouver for a holiday and was using heroin, sentenced to two years for possession of a dirty syringe—a syringe that is analyzed when sent to the laboratory for investigation. There wasn't, I suppose, not a hundredth of a cent's worth of heroin in it, but he got a two years sentence.

At the same time there are physicians, nurses, druggists and dentists and veterinarians who are drug addicts who never get into jail, the excuse offered being that the doctor has a license to be in possession of narcotic drugs, but he's an addict for exactly the same reason that the socially handicapped person is an addict. He is a weak personality who was curious to know what drugs were like and continued to use drugs because he liked them. The myth should be exploded once and for all that these doctors become addicts because of over-work in their practice. It just isn't true. And a physician drug addict having the responsibility for the health and lives of sick people who go to them, is certainly a menace to society. But the physician addict is treated by the law and the narcotics division and the police with the greatest consideration and gentleness, in marked contrast to the way the socially handicapped addict is

used by the law and by the police. I am not finding any fault with the police; as a matter of fact I have been impressed with the earnest, humane and intelligent way they carry out their duties, both the narcotic officers of the Vancouver police force and the narcotic officers of the R.C.M.P., but they have their instructions as to methods of search and they employ them conscientiously. But, as a physician, I resent the fact that we physicians and other professional people are given preferred treatment as compared with the socially handicapped people, even though we have had many advantages in our homes and training and education that give us less excuse than they for indulgence in the narcotic habit. I am not suggesting that physicians who are addicts be treated as harshly as the other group, nor am I advocating that the socially handicapped group be treated as leniently as the physician group. But I am contending that the same general principals of law and treatment be extended to both groups. The physician addict can get his drugs cheaply, through legal or semi-legal channels and he has the money to buy them. He is not treated harshly by the law. The socially handicapped addict has to pay an enormous price for the same drugs and has to buy them with stolen money if he wishes to continue, get them through drug bootleggers, and is dealt with extremely harshly by the law. He is a very weak personality and in doing what he does as an addict he challenges the power of powerful drugs, the power of a harsh law and the power of a very capable police force. The outcome is inevitable but it should be kept in mind that a person doesn't deliberately choose to be what he is. The delinquent person from whose ranks come the socially handicapped addicts is what he is because of inheritance, the type of parents and home in which he was raised, his economic and other social handicaps. The physician is what he is because of his inheritance, the type of parents and home in which he was raised and his economic and other social advantages. Weak personalities exist in both groups, some of whom become drug addicts. If compulsory treatment is to be applied it should be applied to both groups equally. If punishment in prison is to be applied it should be applied to both groups equally, modifying the law if need be to see that both groups are treated equally, in contrast to the extreme leniency now shown the professional group and the extreme severity now shown to the socially handicapped. I am not advocating compulsory treatment for addicts, except in very special circumstances. Much less am I advocating compulsory imprisonment for addicts. I am advocating a thoughtful and sincere re-appraisal of society's attitude to the addict, all addicts, based on actual knowledge of the harmful effects of addiction to the user and to society.

Senator GERSHAW: Is it not a fact, Doctor, that the drugs that the physicians get are recorded very carefully and if he is using the quantity, or anywhere near the quantity an addict is using it would very soon be discovered and his source of supply would be cut right off?

Dr. STEVENSON: I expect that's so. At the same time he is given every opportunity by a very gentle and careful administration to try to get him off. He doesn't have to put up with the problems and difficulties that the other group of addicts have to put up with.

Senator GERSHAW: The quantity he gets though is very strictly limited?

Dr. STEVENSON: No, there are doctors who have been drug addicts for many years and are still drug addicts, where they are getting it I wouldn't know.

Senator HODGES: Mr. Chairman, I'd like to ask the doctor, isn't it a question—to the best of my knowledge—doesn't the law say the illegal possession—?

Dr. STEVENSON: That's the point—

Senator HODGES: What you're suggesting is we should review our interpretation of "illegal possession", as far as the law is concerned.

Dr. STEVENSON: Yes. The whole thing might be reviewed in order that—We say there's no law against being an addict in Canada and that is true. But after all that is the only reason a person is an addict, or has illegal possession, in order to take it for his own personal pleasure.

Senator HOWDEN: It is against the British law to make fish of one and flesh of another.

Dr. STEVENSON: That is the point I am making.

Senator KING: Doctor, I am surprised to learn that there are so many addicts among the professional class. I thought that had pretty well passed away.

Dr. STEVENSON: The figures were given to you in Ottawa which showed three hundred thirty-three members of the profession in Canada are known, to Ottawa, as drug addicts.

Senator TURGEON: Are all those three hundred thirty-three medical doctors?

Dr. STEVENSON: No, about half of them.

Senator TURGEON: What are the other half, nurses—?

Dr. STEVENSON: Nurses, dentists, druggists, veterinarians.

I have nothing else written out about legal sale, or the arguments for and against legal sale. The paper which I wrote and which was published a couple of months—two or three months ago, is before you. (*See Appendix G.*) How do you wish me to deal with that?

Mr. LIEFF: What about legal sale?

Senator HORNER: Would you express your opinion?

Mr. LIEFF: Just in a word.

The CHAIRMAN: There are two matters mentioned particularly in your bulletin here that are of great interest to our committee. One is the legal sale and also you mention the English system. Apparently you have some information on that which you wouldn't mind touching on after you complete the previous subject. It's most important that we hear all we can about the English system and the free sale of drugs.

Dr. STEVENSON: When I came out here from the East in November, 1953, there was evidence presented to you that a strong recommendation had been made for legal sale of narcotics by the Community Chest's committee on addiction, and it had met with a good deal of discussion. I told the committee when I first met with them that this would be one of the subjects which we would study, the pros and cons of legal sale, so it has been studied now for well over a year before this paper is written. The suggestions made by the committee and by some of the addicts themselves were that legal sales, as a part of a general controlled plan, if you like, a clinic should be set up where registered narcotic users could receive their minimum required dosage, and that this register would maintain a constant check up on the number of addicts in the community, the protective life of the addict and support him as a useful member of society, the assistance he would get would hasten his rehabilitation, or at least reduce the amount of his addiction since many of the stresses of the addict's life would be reduced, and that this action of setting up clinics would ultimately eliminate the illegal drug trade. Some of the additional points made by the addicts in discussing it with them, that if drugs were easily available the cost would be nominal and the addict could support a modest habit from his wages. He would not be in constant conflict with the police, nor would he be sent to jail. Absence of police arrest and jail sentences would enable him to work steadily and maintain his home and family and

respectability. Employers are reluctant to employ anyone with a record of jail sentences so that if drugs were legal it would enable him to avoid them in that way too.

If he could buy drugs legally he wouldn't have to pay the exorbitant prices of the black market. And addicts claim that they are less of a danger to society than people are with alcohol in their circulation. He contends, that is, the addict contends that with herion he only wants to be quiet and relaxed whereas the alcohol user is apt to be aggressive and dangerous. Also, if drugs were legal, they would lose their glamour and adolescents would not be attracted to them as they are now. Some addicts complain too that having learned to like narcotics they resent the legal prohibition and are all the more determined to get them in much the same way as in the days of alcohol prohibition when people thought it smart to out-wit the police, patronize boot-leggers and generally show their defiance of the alcohol prohibition law.

Now, these arguments sound attractive when you read them and hear them in this way. The addicts quote them and believe them and various books have been published advocating legal sale—

Senator LEGER: May I ask a question at this moment? How would you go about having these clinics? The patient, for instance, who has to take four, or five, or six injections a day?

The CHAIRMAN: He is just outlining the recommendation of another group—

Dr. STEVENSON: You understand, I am not advocating legal sale, I was reading out their statement, and I discuss that a little further in the paper here. That is, I think, one of the difficulties, that, even if it were the wise thing to do, it would be very questionably impossible.

Senator HOWDEN: It's not the wise thing to do, doctor, I don't think.

Dr. STEVENSON: No, I'm quite satisfied that it isn't too. But legal sale—I discuss here two possible means—one is the setting up of narcotic clinics, such as they had in the United States thirty years ago, and you have that pamphlet now which gives the history of those clinics. In that pamphlet too is an article by Mr. R. S. S. Wilson who replied to the Chest's recommendation for legal sale, a very fine paper it is too.

The CHAIRMAN: As a matter of fact, that idea caught like wild fire, I've received all kinds of letters saying that is the cure; you remove the top men from it if you do that.

Dr. STEVENSON: That is what I am going on to say, that in countries where legal sale has been used it has never reduced the profit motive, it has never reduced the illegal sale, illegal sale has increased, whether it's China or other oriental countries, or in the United States when they had clinics, where addicts could get their drugs legally thirty years ago, the number of addicts increased and the amount of illegal drugs increased and the criminal population and prostitute population from all over the United States flocked to the centres where these clinics were set up, increasing—

Senator HORNER: A question there doctor. Did they not, in the United States, did they not allow the addicts to take the drugs away with them?

Dr. STEVENSON: That's right. They were allowed to take it home with them.

Senator HORNER: Well, of course, I'd never be in favor of that. I would expect that would be the result.

Dr. STEVENSON: I don't know what the recommendation would be of any people here, about that, but the point the other senator raised, it would mean that the addict would have to go down five times a day, that the clinics would have to be open twenty-four hours a day, seven days a week, and be staffed.

You would have to have them in all parts of the Province—you'd have to have them in all parts of Canada probably, because it would be a Canadian law, or possibly each Province might have the right to implement it or not as it saw fit.

Senator LEGER: Several parts of a city, too.

Dr. STEVENSON: Yes, and addicts who are addicts in Vancouver and have a chance to go to a job away up in some far part of the Province, they would have just as much legal right to their drugs there as they would have in Vancouver.

Senator LEGER: It is hardly feasible.

Dr. STEVENSON: There is an endless series of obstacles to that sort of clinic and they are covered in this paper. Well, then, incidentally, I make a point there which is interesting to me at least—

Senator HODGES: Could we ask the page you are on, doctor?

Dr. STEVENSON: I'm on page five right now.

Mr. LIEFF: At the top of the page.

Dr. STEVENSON: I haven't been following it too much in detail.

The point I just want to make is this wide divergence of opinion as to how harmful drugs are, when some people advocate the most punitive measures towards the addict, and other people want to give them drugs free.

The CHAIRMAN: Was the drug thirty years ago heroin in the States when the clinics were put in?

Dr. STEVENSON: No, it was largely morphine. But that's another point I make, that if an addict prefers heroin, or cocaine or marijuana, does he have the right to get the drug of his choice at the proposed free clinics? In other words, you'd have to stock up a variety of brands, as it were, as is done in the liquor dispensaries.

Senator HODGES: Yes, but in the liquor dispensaries you don't provide it free to alcoholics.

Dr. STEVENSON: No, that's why I don't see why they should get their favorite drug free. Nobody gives me free coca cola.

The CHAIRMAN: Don't tell me you're taking drugs, doctor.

Dr. STEVENSON: On page six I discuss some of the defects of those earlier clinics in the United States, some of which I've already mentioned. I won't repeat them all again. Criminals were coming from all parts of the country—no attempts were made to cure the addict, the clinics were merely dispensaries for issuing the drugs, there couldn't be a basic minimum dosage as the Chest brief recommended because addicts are only satisfied that is a starting point. The mere fact that they are heroin users means that they almost have to increase their dosage and what they can't get legally then they would still patronize the bootleggers for the amount he wants. More than one addict has told me that they wouldn't be interested in getting a minimum amount, they want enough to get real high on.

Senator HOWDEN: Is marijuana as narcotic a drug as opium?

Dr. STEVENSON: No, it isn't, and it doesn't build up tolerance. The person doesn't have to take larger and larger doses of either marijuana or cocaine, and it can be stopped much more easily than the heroin habit can be stopped. There is no marijuana in this area to speak of at all. In the United States—

Senator HOWDEN: I didn't think it was.

Dr. STEVENSON: In the United States marijuana is a very popular drug of addiction.

Mr. LIEFF: There are no withdrawal difficulties?

Dr. STEVENSON: No, there are no withdrawal difficulties.

Senator BEAUBIEN: Doctor, suppose if you establish these clinics, just for arguments sake, and all the narcotics would go to this clinic, how would the bootleggers get any to peddle around?

Dr. STEVENSON: The same way they do now. All the heroin they're selling now is made in secret factories in Europe mostly and it's handled entirely by the underworld syndicates. That is a point I thought of during the lunch interval. The question was raised about all the opium in China. It has to be converted into heroin and a lot of that is shipped to Europe to be converted into heroin in the clandestine factories and then crosses the ocean to New York—that's how it gets from China to New York, and then back to—

Senator TURGEON: It comes into New York illegally, does it?

Dr. STEVENSON: Yes, entirely. Fifty countries in the world have now agreed not to use heroin legally, Canada being one of the last, as from the first of January last, no new heroin could be imported into Canada for doctors to use. They can only use up existing stocks.

Senator KING: And fifty nations have—

Dr. STEVENSON: Fifty nations have agreed to ban heroin even for doctors uses because there are other drugs that are as good or better than heroin.

Page seven takes me to the English system, because so many addicts have the idea—and the general public too—they say why can't we have the English system. And they're under the impression that the English system involves the legal sale of narcotics to any one who wants to buy it and that he even gets his drugs free from the Government, under the Government health scheme, but that isn't so.

I'm sorry, I need to go back a page or two also about these clinics. A second method of legal sale that's been advocated by some people in this Province is that, don't set up clinics, let the doctors themselves be the clinics. Doctors are in all parts of the Province, they work twenty-four hours a day, let them supply the drugs at any addicts request. And the medical profession resent that strongly, that they should be vendors of narcotics simply for the perpetuation of a vicious habit.

The English system, which I go into a little more on page eight, the laws there are pretty much the same there as they are here. They have a dangerous drugs act corresponding to our opium and narcotic drugs act and the same regulations apply that people have to have a license to be in possession of drugs and that drugs cannot be supplied to an addict simply for the perpetuation of his addiction, they can only be given for sound medical purposes. But they have so few addicts in England, only about three hundred are known to the authorities, and under certain conditions addicts can and do get narcotic drugs from doctors. If an addict goes to a doctor, say an addict from Canada would go to England and had a supply with him which he got here illegally, he could go to a doctor in England but he couldn't demand a constant supply of narcotic drugs. It would be the duty of the doctor to try to cure him. That's the doctor's job, to treat and try to heal such people. The doctor is obliged under his medical ethics to try to cure this man, not to perpetuate his addiction habit, but under two conditions the doctor may give—three conditions—he may give the man drugs. He may give any patient drugs of course if the patient needs them for sound medical reasons. But if a man is just an addict, then there are just two conditions. One is, if he thinks, if he gets the patient (we'll call him a patient) reduced to a very minimum amount and the patient shows signs of collapse or if the doctor fears the man is going to die, then he is authorized to give him what drugs he thinks will keep him alive rather than have the man die on his hands. We know in this country that addicts don't die from with-

drawal symptoms—I've never personally known an addict to die from being deprived of his drugs. But they have this extremely cautious attitude in England so that the doctor who perhaps may see only one or two addicts in a lifetime protects himself by being allowed to give very small quantities until he gets a man cured, or until the man goes some place else.

Secondly, if the patient is working at a job and he gets so jittery and gets withdrawal symptoms and he comes to the doctor and pleads that he can't hold his job because of his symptoms, that he must have some drugs to keep him going, a doctor is authorized again to give him minimum quantities of drugs until, again, the man is cured or leaves. The doctor is not authorized to give him drugs permanently merely for the sake of continuing his addiction. That is the English system.

The CHAIRMAN: What drug do they use, doctor, mostly?

Dr. STEVENSON: Heroin is still available in England so whether it be morphine or heroin I wouldn't know, but it would be one or the other.

Senator HODGES: Doctor, there's one point—I have your pamphlet here—I notice you say, quoting from page seven, it says, "If Britain has an underworld, narcotics have never been common among its members and are virtually unknown among the prison population of Britain. British authorities have never allowed narcotics to get a foot hold on the people." What exactly does that mean? What steps did they take?

Dr. STEVENSON: Well, they never had the oriental influx that we had on this continent for one thing.

Senator HODGES: They had a big population though, and anyone who knows England and the dockland areas knows they get a great many Asiatics.

Dr. STEVENSON: There is an oriental population in Liverpool which still smokes opium and gets opium illegally and if they get it illegally they are punished, they are punished by fines as a rule. Because smoking opium is not one of the things a doctor is allowed to give. Any drug has to be given under doctors' orders. In London, England, there are some colored people who bring in marijuana or even demerol around some of the cheap dance halls and places of that sort, and they try to sell it to the adolescents and young people there who are looking for a kick and a thrill. If they do that, they are punished by the law. But here, you see, in our B.C. Penitentiary here, there are a large number of addicts, and in Oakalla a large number, but in the prisons in England (I've had correspondence with them in England) a drug addict is a rarity—extremely rare—however, firstly, they don't send them to jail as a rule, even these people who get it illegally. They're usually fined or something of that sort and then they disappear or leave the country or move to some other part of the country. Whereas, the other people that are getting—these three hundred who are getting their drugs from doctors, where the doctor is supposed ultimately to get them cured, they don't go to jail because they're in legal possession of their drugs; it has been prescribed by the doctor.

Senator HODGES: Yes, but there are forty-eight million people there and people concentrated in small areas, large concentrations of population, and the curious thing is that, although you say there are drug addicts—marijuana and the other opiates—it's a curious thing, and they also have situations which we have in British Columbia where you get maladjusted people in poor homes and that sort of thing, and yet the spread of it hasn't been comparable.

Dr. STEVENSON: That's it. That's the point I made this morning. Buyers bring sellers and sellers bring buyers. If there are no sellers there, there can be no buyers of the drugs. If there are no buyers there, there's no business for a person to go in and try to sell drugs. He'd be caught by the police very quickly. It's much the same as it was in Japan. One of the most interesting

historical features is to compare China with Japan. China had a terrific opium smoking addiction problem as you know, during the latter part, all during the nineteenth century into this century. Japan has never had a drug problem at all, for the same reason that England has had no problem. They wouldn't let drugs illegally into the country, so no Japanese ever became addicted. When I say "no"—I don't know of one. Even here, in British Columbia, where we have fifteen thousand Chinese and seven thousand Japanese, still, even after those who left the province, there have been something like one hundred and fifty Chinese since 1937 have been convicted but only one Japanese in British Columbia in that whole time. There is a cultural tradition in favor of opium, if you like, in China. There has been a cultural tradition opposed to narcotics in Japan.

Senator HODGES: The point I'm trying to get at doctor, is you say British authorities have never allowed narcotics to get a foot hold.

Dr. STEVENSON: That's right.

Senator HODGES: You are inferring by that, that it has been a laxity on the part of the authorities which has allowed drug addiction to become, to assume the proportions it has here.

Dr. STEVENSON: No, I wouldn't say a laxity on the part of the authorities. It was perfectly legal, nobody thought there that there was anything wrong with the Chinese who were brought in to build the railroads a century ago. Nobody thought there was anything wrong in them having opium and thousands of tons of opium were imported for the Chinese' use, and having got so many orientals into Canada and the United States, then it spread from them to the white populations. That's one of the points I mentioned this morning.

Senator HODGES: Yes, I remember your saying so.

Dr. STEVENSON: And much the same in Japan. Formosa had a somewhat similar problem when Japan took over Formosa at the end of the last century. There was a large addiction problem in Formosa. Of course it had previously been a Chinese domain and Chinese people largely. Well, the Japanese started to impose the same rules they had in their own country—Japan. But they did something which is now being recommended by the Chest committee and others. The people who were addicts in Formosa, Japan said we will let them, above a certain age continue to get it legally, we will register them. And that was the plan, I think, as long as Japan was in control of Formosa. So there was a gradual reduction, but at the same time, there were some years in Formosa when the illegal supply of drugs smuggled in exceeded the legal supply. The same thing applied in Hong Kong, as I mention in this paper. Far more people got their drugs, even when it was perfectly legal to get it, far more of them got it through illegal channels than through legal channels.

Senator TURGEON: Returning to England for just one question, would it be fair to assume that part of the record for so few cases in England, compared to Canada, would be because so much fewer are recorded there as criminals?

Dr. STEVENSON: You mean of the total criminal population?

Senator TURGEON: Yes.

Dr. STEVENSON: No, —

Senator TURGEON: In connection with drugs. There are so many fewer drug addicts in England, would that be because, I notice here, that there is not the same recording made of all addicts.

Dr. STEVENSON: Addicts are not registered in England. If an addict goes to a doctor the doctor has to report him by name to the home office in London.

Senator TURGEON: So that there would be a record of it, then?

Dr. STEVENSON: Yes, but they don't call it a register. A person isn't officially on a black list as it were.

Senator TURGEON: When we're talking about the English record, would that be the official record or the total record?

Dr. STEVENSON: Well, that's the total record. That is all they know about. The number has gone some years from two hundred and fifty perhaps to four hundred and fifty and it's gradually coming down, even those that are known to the medical profession and reported to the home office.

Senator HODGES: It doesn't necessarily follow that those are the only addicts?

Dr. STEVENSON: No, there are secrets here, there are probably secret addicts there, but—

Senator TURGEON: I meant the system there.

Dr. STEVENSON: The system takes care of all of them so far as they know and so far as anybody else know.

Mr. LIEFF: Those are the white drugs we're talking about now, the figure of three hundred?

Dr. STEVENSON: Yes.

Mr. LIEFF: Have you any idea what the figures are on the dark drugs, marijuana, hashish, and so on?

Dr. STEVENSON: No, I have no figures on them at all, except the ones I saw from recent reports from London, England, was that marijuana and demerol are circulating in the black market in London, England, but, in what we would call here, very small quantities.

Mr. LIEFF: You have no idea how extensive the use of marijuana is in England?

Dr. STEVENSON: Except that I think it's very small.

Mr. LIEFF: I see. Could you tell us anything about seizures. We read about rather substantial seizures of narcotics in the ports there. Do you know anything about that?

Dr. STEVENSON: Yes. I have seen the English report. All the countries that are members of the United Nations send in annual reports, as you know, and I have seen these reports. They do make seizures and there again the drugs that are seized are usually for the Oriental population of Liverpool or London or wherever the groups are, or for the people from India or Africa who are in the habit of using marijuana or hashish, or some of those drugs.

Mr. LIEFF: Have you ever heard it said, by people in explaining the number of seizures, substantial seizures, that this is "stuff" in transit to America or other places?

Dr. STEVENSON: I don't think I can answer. I just don't know. I don't remember anything about that. The police force would know much more about that than I would know.

The CHAIRMAN: Doctor, how is Japan able to make such a good job of keeping drugs from entering Japan illegally?

Dr. STEVENSON: Well, they adopted that in the very early days when Japan opened its country to foreign trade and with the knowledge of what had happened in China through the so-called opium wars and the large use of opium there, the Japanese said we want no part of opium addiction in Japan. They said that in effect, and consequently, not having any addicts to start with, they didn't let their people become addicted. They kept out any drug that might have been smuggled in. And there again, if somebody had smuggled in drugs into Japan, they wouldn't know who to sell it to because there was

nobody with the habit or knowing about it or wanting it. So, Japan has been virtually a non-addiction country. More recently, of course the Japanese during the recent war and since, I am told that benzadrine has become a popular drug of addiction among adolescents in Japan.

The CHAIRMAN: It's amazing, doctor, because Japan herself went out to conquer China by opium.

Dr. STEVENSON: I'm sorry, I didn't—

The CHAIRMAN: She went out to conquer Manchuria, China with drugs.

Dr. STEVENSON: Who was that?

The CHAIRMAN: Japan.

Dr. STEVENSON: Oh, yes.

The CHAIRMAN: It is strange that she kept her own country free and yet she used these drugs to conquer China.

Dr. STEVENSON: That's right.

The CHAIRMAN: It's well known that Japan went out on a world conquest with opium.

Senators HODGES: One thing I would like to find out is whether the supply creates the demand or whether the demand creates the supply.

Dr. STEVENSON: It works both ways, Senator. Here in Vancouver, as I mentioned this morning, there are a thousand people who want drugs. That brings the merchants in—illegal merchants. And we have a stable market here and a number of merchants selling drugs, people from other provinces, or people already here, they say, well, we know where we can get it; they want it every day, so they know where they can get it. Buyers bring sellers, sellers bring buyers. I think it's about as simple as that,—that part of it.

Senator HODGES: Yes.

Senator STAMBAUGH: Doctor, do you think the method of keeping track of addicts in Great Britain is as effective as it is here? Do you think, for instance, that three hundred is practically all the addicts there are there?

Dr. STEVENSON: I'm satisfied that's all there are.

Senator HORNER: What about the cocaine leaf? Is it the Asians who chew that and get—

Dr. STEVENSON: No, that's used down in South America, in Peru, Equador and Bolivia, especially. Much the same argument is used there as was used about opium in China fifty to one hundred years ago, and the point was raised this morning—that the poor people of—with a lot of hard work do do, that if they can get opium they work so much better. Well, that argument was used in South America and the wealthy people even paid the poor peasants in cocaine to keep them addicted and everybody is opposed to that method now. Cocaine is not needed by them, they don't have it for their troupes in South America and the South American countries realize that it was a trick—if you like—to keep people in poverty and subjection by giving them narcotic drugs.

Senator HODGES: Doctor, one thing I was interested in, I think you said this morning that in your opinion most of the drug addicts become drug addicts through associating with other addicts, not necessarily through pushers.

Dr. STEVENSON: That is right.

Senator HODGES: And yet, at the same time, you said a few moments ago, that buyers come in, sellers come in. Well, don't you think that the seller of drugs is like the seller of any other merchandise? He's going to do all he can to increase his sale?

Dr. STEVENSON: Well, the police will know the details of that better than I, but addicts tell me—there is the wholesaler, the middle-man, the retailer, a whole chain of people. The people who peddle it on the street are mostly addicts. But the people in the upper brackets don't use drugs at all.

Senators HODGES: No, quite.

Dr. STEVENSON: And in between you may have people who don't use and some, as they get down to the street level who use it, and that's about the situation.

Senator HODGES: But the pusher, the so-called pusher, isn't he the man who creates new addicts?

Dr. STEVENSON: No.

Senator HODGES: You don't think so?

Dr. STEVENSON: No, I have no reason to think that. The addicts take a peculiar pride in saying, (How true it is I don't really know of course) but they like to say that they've never tried to sell drugs to anybody who wasn't already using them. And when you ask most addicts, "Well, how did you get your first fix"—well, I told the people that I was with that I had used it before, is their answer. Something of that sort.

Senator HODGES: Well, do you think you can put any reliability on their statements?

Dr. STEVENSON: I think so. I'd certainly accept that preferably to thinking that anybody is going around trying to seduce or solicit new customers. I think the police, their evidence, will support that point of view.

Senator HODGES: And yet we're told on the other hand, we hear of drug rings which make tremendous profits and it seems to me, it isn't human to suppose that they are not going to try to make more profit and get more customers, if one could use that word.

Dr. STEVENSON: Well,—

Senator HODGES: I would like to believe that they didn't, but I mean—

Dr. STEVENSON: Well, I believe it. I haven't been told, as I mentioned this morning, only one addict out of three hundred I've interviewed, has ever indicated that an attempt was made to get him to buy. Most addicts, too, claim they try to persuade young people to stay away from it. I don't know how much drug is available but the profits—take ten cents worth of heroin selling for four or five dollars, the profits are enormous, and with the amount of heroin that is available and the number of people there are to buy it, apparently they are satisfied. So far as I know, there is no pressure on any non-using group to buy drugs.

Senator LEGER: They are afraid to get caught.

Senator McKEEN: Your point is that the man selling drugs is trying to get a larger share of the market that's already there?

Dr. STEVENSON: Yes, whatever competition there is, and I have no personal knowledge of the syndicate, so called, but it seems to be that that is the answer.

Senator McKEEN: Something like a firm selling gasoline, they don't create more gasoline customers particularly, but they try to get the biggest share of that market that they can.

Senator HODGES: At the same time they try to get more customers judging by the advertising.

Senator McKEEN: Yes, but from people who are already using gasoline.

Senator HODGES: To use more gasoline?

Senator McKEEN: They don't tell you to go buy an automobile to use gasoline.

Senator HODGES: I don't know. I wouldn't put that past them.

Dr. STEVENSON: That's the English system so far as I know it. On page eight I give some of the details which I have already mentioned; page nine I mention certain other people who have given excellent papers including Mr. R. S. S. Wilson who is listed to be one of your witnesses. I may not be present when Mr. Wilson's evidence is given, I might say it is a fine paper although he favours compulsory, long detention in a penitentiary narcotics hospital which, of course, I don't go along with.

Senator HORNER: You don't agree that it helps better in prison. You think it should be some other method?

Dr. STEVENSON: Imprisonment doesn't help an addict. It may keep him off the street, it may keep him out of crime, and for whatever that is worth, that's all it does.

Senator LEGER: You don't favor clinics either?

Dr. STEVENSON: Legal sales clinics? Drugs by legal sale? Oh, no, I'm very much opposed to legal sale in any form.

Senator HORNER: You're in favor of a clinic, though, doctor? For treatment?

Dr. STEVENSON: The term "clinic"—

Senator LEGER: Cure clinic—

Dr. STEVENSON: The term "clinic" is a misnomer when it is applied simply to a legal outlet. That's one of the curious sort of twists of logic when we speak of narcotic clinics. They're not clinics, they're just dispensaries.

Mr. LIEFF: Filling station—

Dr. STEVENSON: I wouldn't call it a filling station. I'd call it something same as a beer parlor. It's the same thing. You might as well call a beer parlor an alcoholic clinic. It's just as logical.

Senator HORNER: A rehabilitation centre—

Dr. STEVENSON: A rehabilitation centre. I am strongly in favor of that.

Senator LEGER: But you are not in favor of these clinics?

Dr. STEVENSON: No, I'm not in favor of legal sale in any form, because I think it would not solve the problem, I think it would make the problem worse. I think that's about the story, Mr. Chairman.

The CHAIRMAN: Any other questions you would like to ask Doctor Stevenson. If not, doctor, may I thank you most sincerely for your splendid presentation you have made.

We have with us Doctor MacLean. Doctor MacLean, will you come forward, please?

Dr. MACLEAN: Mr. Chairman, Senator Hodges, and gentlemen. I would like to say that I consider it a privilege to appear before you. I feel the appointment of such a commission is a major step forward in the social progress of this Country and I am happy to render such assistance as I am able. I would like to make it very clear that I speak as a general practitioner who makes no claim to expert knowledge in the field of narcotic addiction. However, I have had some personal experience with narcotic addicts and in 1951 I was privileged to serve on the first committee established by the Community Chest and Council of greater Vancouver to study the drug problem.

Bearing in mind the ethics of my profession, I would also like to make it very clear that I do not represent any organized medical group and the opinions which I propose to present are my own and are not necessarily shared by others in the profession.

I first became interested in narcotic addiction through the efforts of a private detective and a well known Vancouver reporter who were patients of mine.

They outlined to me the difficulties faced by addicts in securing treatment to help break the drug habit, and, over a period of time, the decision was formed to try an experiment in treating seven addicts.

The organizing group was strengthened by the addition of a clinical psychologist whose task it was to carefully screen the addicts to determine their suitability for this type of experiment. We wanted to assure ourselves that the addicts were sincere in their desire to break the drug habit.

My previous experience in treating drug addicts in private hospitals and sanatoriums had led me to believe that the interest of most of them was only to reduce their drug habit to a point at which it was possible to maintain it within their economic limits. In other words, how much they could steal or raise by prostitution. They were not really concerned about breaking the habit entirely.

Senator HODGES: Doctor, excuse my interrupting here. Are you referring to that group of seven or speaking of addicts generally?

Dr. MACLEAN: Right now I was speaking of addicts generally.

In our experiment, we wanted to avoid this type, if possible, and for that reason set up the screening process with the psychologist who made use of various psycho-diagnostic tests to help us select the group of seven.

Detailed accounts of the social, economic, educational, and criminal background were taken and checked as closely as possible. All, told, some fifteen to twenty addicts were tested before the group of seven finally was selected as the best suited for the program we had in mind.

It was our intention to discover, if possible, if a chronic drug addict, without being rigidly controlled in an institution, could be freed of the drug habit and returned to a useful role in society through his own desire and effort with the help of limited treatment and rehabilitation.

We realized our facilities were limited, but as far as we knew, it was a new approach and we felt it would at least shed some light on the problem and provide us with further knowledge relative to the problem.

The treatment consisted of gradually diminishing doses of heroin by injection twice daily in my office. The addicts were pledged not to take any more drugs by self-injection. The intention was to gradually reduce the daily intake over a period of several weeks or months, depending on the severity of the individual addict's habit. It was hoped that this method would bring the addict to the stage where the habit could be cast off without the occurrence of the distressing symptoms associated with an abrupt withdrawal. As you gentlemen probably know, these symptoms can be terrifying and horribly painful when withdrawal is abrupt. The addict's bodily functions over a long period of taking drugs have been drastically changed. For example, bowel habits diminish to as little as once weekly; desire for food is reduced to the point where the addict finds a chocolate bar or two a day will satisfy his or her appetite, but with consequent detriment to their health. In the case of women addicts, menstruation slows and in some cases stops.

Then on sudden withdrawal of drugs, there is a great surge of activity in these functions, so that gastro-intestinal contractions become almost unbearably severe. Violent cramps, nausea and vomiting, diarrhoea, streaming eyes and nose, and in the women, menstrual hemorrhage, are commonly experienced by the addict at this time.

It was our thought that the severity of withdrawal without treatment might be one of the reasons why addicts did not attempt to rid themselves of their affliction.

The treatment also included individual and group psycho-therapy of a very limited nature and all the addicts obtained employment. All members of the treatment group made a determined effort to encourage the addicts in their endeavor and to establish friendly relations with them.

At one stage in the experiment three of the group of seven lived in my home. This served the dual purpose of giving them a new experience of family life and giving us a chance to make sure they were not taking drugs in excess of the controlled dosages.

We carried the experiment to the point where all the addicts were down to a twelfth of a grain of heroin per day after several months' treatment and at this stage it was decided that withdrawal should be complete. Two of the seven, a married couple, at this point came to me and said they could not continue, that they felt it was beyond their powers. However, the husband, as far as I know, is still employed on the job which our committee obtained for him and in spite of taking drugs has not been in trouble with the police.

Another woman stopped taking drugs, continued on her job and within a few months was happily married. However, shortly after her marriage, her husband was killed in an industrial accident and she was not emotionally stable enough to take this bereavement without returning to drugs.

Another married couple entered a nursing home for a few days to undergo the final withdrawal, which they successfully completed. Then they obtained out-of-town employment and we lost contact with them. I have heard since, however, that both have been taking drugs again.

One man completed his withdrawal in my home for ten days. We obtained for him an out-of-town job, which he successfully held for five months, but was dismissed when local R.C.M.P. officers informed the employer he had been a narcotic addict.

Senator HODGES: May I interrupt you there? Why did they inform? Did the man do something, commit a crime? Was there anything wrong?

Dr. MACLEAN: Well, he was a known addict and criminal and from what I understand, when this became known to the officer he made it known to the employer.

Senator HODGES: He hadn't done anything in his current job.

Dr. MACLEAN: No.

Senator HODGES: Thank you. Excuse my interrupting.

Dr. MACLEAN: We have not had direct contact with him, but again I learned indirectly that he, discouraged by this turn of events, had reverted to drugs.

I would like to make it clear at this point that there is no criticism of the police implied in the above reference. It is their duty to inform employers when men with criminal records are found on the payroll. But I also would like to point out at this time that this constitutes one of the major stumbling blocks in the rehabilitation of drug addicts, or, for that matter, any criminal I would suppose.

The seventh addict, a man, took a job and held it successfully as long as he was on a minimum dosage. But he could not complete the withdrawal and reverted quickly to his former status when we decided to discontinue his limited supply.

You will remember that our purpose in this experiment was to discover if a chronic addict could with limited help, and without strict control in an institution, stop taking drugs and rehabilitate himself.

In this respect, our experiment seemingly produced a negative result. But this experience, together with other addict problems I have encountered, brought to light what appear to be some basic facts about drug addiction.

Whether these facts would be applicable to drug addicts in general is impossible to say without wide scale study. But in view of the limited knowledge of drug addiction at present, I believe these observations are pertinent.

The outstanding fact is that all the addicts I have encountered are people with marked emotional maladjustment.

In every case, they had very bad family backgrounds. For example, one of our girls at twelve years of age was sleeping in the same room her aunt carried on prostitution in. Because of this type of background, we found that without exception, these people were emotionally unstable, mostly neurotic, and some exhibiting psychopathic personalities.

Setbacks, difficulties and disappointments which the average, emotionally stable, and mature person takes in his stride, prove a crushing burden to these people and they turn to narcotics as a medium of escape much as the alcoholic turns to liquor.

This was glaringly apparent when our addicts tried to make their way without drugs as was exemplified by the woman who lost her husband, and the young fellow who lost his job. These are admittedly serious setbacks for most people, but only the very emotionally insecure need a crutch like narcotics to see them through the time of difficulty.

Because of this marked emotional maladjustment, we feel that the chronic drug addict is not curable in the sense that they can stop taking drugs for the remainder of their lives.

But it is apparent that many of them, in fact most of them, can fill a useful role in society, some in better-than-average fashion, if they have access to drugs. This is substantiated not only by our limited experiment, it is a well known fact that there are many addicts who either through wealth or position, are able to obtain supplies of drugs without getting into trouble with the police.

And to keep drug addiction in what I consider a truer perspective than that commonly extant, I would like to point out that it is not the only form of addiction afflicting numerous people today. There are at present in B.C., an estimated two thousand drug addicts. At the same time there are an estimated twenty thousand alcoholics of various degrees—and the term alcoholic is just another name for a person addicted to liquor. There are food addicts—people who ruin their lives and sometimes the lives of their loved ones because they cannot control their appetite for food and will gorge themselves into a state of ill-health of serious proportions. There are people addicted to promiscuity, and this is becoming an increasingly serious problem.

Basically, emotional instability underlies all these problems and the point that I am trying to make is that the problem of drug addiction, while singled out as a particularly heinous crime, is not necessarily so.

Drug addicts are popularly saddled with the blame for most of our petty crime. But a learned magistrate in our city recently said that eighty-five percent of the cases which appear before him are in court because of alcohol.

It is also a generally accepted fact that heroin addicts do not commit violent crime. While there recently has been in Vancouver an upsurge of violent crime, it must be borne in mind that as far as we know, these shootings, bombings and killings were not committed by the addicts, but by the unscrupulous drug traffickers fighting with animal-like ferocity for control of the lucrative illegal drug market.

Bearing these things in mind, it seems to me that a more realistic approach is needed to the problem of drug addiction.

No one suggests that the alcohol addict should be thrown in jail every time he is found buying his favorite drug; none suggests that the food addict should be jailed for indulging beyond reason; nor is it suggested that the promiscuous

man or woman be imprisoned for their actions, detrimental though they may be to themselves, their loved ones, and society as a whole. Why then, single out the drug addict for incarceration.

Why not accept the fact that the majority of the estimated five thousand addicts in Canada are suffering from an incurable disease, and then go on to deal with the problem.

Because drug addiction is incurable, a huge and sordid racket has flourished for years, not only in Canada, but in other parts of the world. I refer, of course, to the traffic in illegal narcotics. Because it is the only source of supply available to the majority of addicts, and because its price is exorbitant, most of the addicts are forced to turn to crime and prostitution to meet their needs. In consequence the pattern of crime and vice is compounded many times over, and the cost of coping with it through jails, law enforcement bodies, and the loss of productive labor, runs to many thousands and probably millions of dollars annually.

But much of this enormous cost, which must be borne by the taxpayers of Canada, could be abolished if drugs were available to addicts at the legitimate price. A drug habit could then be supported for about the same cost as a cigaret habit and the addicts, or at least the majority, could perform some useful job and lead a more or less normal life.

I am not suggesting that legal supplies of drugs alone would solve the problem. But it would cut the ground from under the drug profiteers and eliminate much of the vice and crime connected with drug addiction.

And from that point we could go on to make sure that drug addiction would not become a perpetual problem. It could not be solved overnight, but in my view it would be possible to end it as a serious social menace within the life span of the present known chronic addicts.

As things stand now, the problem, in the face of present methods of dealing with it, is not getting better. It is, in fact, increasing.

This problem, as I see it, breaks down into three main phases. First there is the problem of dealing with the present five thousand known chronic addicts. Secondly, there is the problem of illegal traffic and its attendant vice and crime, both springing from a greed for high profits, and thirdly, there is the problem of the newly created or potential addict.

The first two phases of the problem, namely the existing chronic addicts and the illegal market, can be met through the establishment of a legal distribution of drugs at prices which normally prevail. This would supply the needs of the chronic addict, free most of them from a life of crime and permit them to perform some useful job. The racketeers, with their enormous profits gone, would be forced to close up shop.

That leaves us with the third phase and it is possibly the most difficult problem to handle because of all the factors involved.

But I believe that a new medical and legal approach to it would produce results which we are not getting under the present system.

Medically, we should establish drug addiction as a reportable disease, as is tuberculosis, typhoid, syphilis, and many others. This would give us a degree of control over the disease which we do not have at present. We would know the number of cases, and discover many of them before they became chronic or incurable. In addition, the establishment of drug addiction as a reportable disease would tend to change the public attitude toward it. It seems reasonable to suppose that in a short time drug addiction would be recognized as an illness not necessarily associated with crime, but as something that was basically the result of an emotional problem.

On the legal side, we should take steps to make sure that the illegal traffic is thoroughly suppressed. In addition to legal distribution undermining the profit motive, penalties for trafficking in any form should be drastically increased.

If the traffickers knew that they faced penalties of twenty or more years—and the certainty that these penalties would be imposed—then I doubt they would attempt to create new markets by encouraging new addicts.

Given this combination of circumstances, I feel that the addict problem would be reduced to a minimum. I say minimum because human nature, emotional stability, and the complexity of modern civilization being what they are, I am not optimistic enough to forecast a complete end to the problem.

In other words, I feel that there will be people who will tend to turn to drugs and who may be able, in one way or another, to establish a habit in an illegal way despite all safeguards we may devise.

Because of this, I suggest it is necessary to establish a procedure for treating these people. This would entail changes in existing legislation so that they could be admitted to hospitals as are other sick people. I do not think they would become a burden on hospital facilities because I feel that their numbers would be few and that under this new approach the chances for rehabilitation would be much greater than they are now.

To sum up, I would like to recapitulate what I consider the main points; these are:

1. An addict forced to depend on the illegal market for his supplies is a menace to society in that he or she will steal or prostitute themselves.

2. The illegal market, because of the greed of its manipulators, tends to create new addicts.

3. An addict, given access to legal drugs, can perform a useful job and lead a more or less normal life, despite his affliction.

4. Methods of rehabilitation presently proposed do not take into account the enormously complex nature of drug addiction and therefore are successful in only a limited way. This was true not only of our little experiment, but has been true with only a few exceptions, in larger rehabilitation projects.

5. Present methods of coping with drug addiction in Canada are not working. There is a feeling in many quarters that it is, in fact, increasing.

6. That the problem of drug addiction has been over emphasized in comparison with other addiction problems—notably alcoholism.

Therefore, gentlemen, I submit that a more realistic and practical approach to the problem of drug addiction is essential.

I realize that it is a tremendously complex problem and I daresay that after hearing all the evidence across this country you learned gentlemen do too. I would, in conclusion, like to offer my best wishes for your success in a difficult undertaking.

Thank you.

Mr. LIEFF: Thank you, doctor. I wonder if I might ask just one question, doctor. You propose setting up some mechanism whereby an addict will be able to get drugs cheaply without going to the illegal market. Now, I wonder, doctor if you could help the committee by telling us whether you have considered who is to be the judge as to how much you would give the addict; how much dosage you would give him?

Dr. MACLEAN: Well, I think I would answer that at this time in this way. It is going to require medical teams in such a distribution centre to control the distribution of this drug. For example, in tuberculosis sanatoriums the team of doctors will meet every sixty days possibly, or every ninety days, to discuss each patient under their care; their problems and their course of

treatment for the following sixty or ninety days, or whenever the periodic checkup occurs. I think probably the doses, etc., would have to be determined under conditions such as those.

Mr. LIEFF: Do I gather from what you say, then, that we would have to have a medical setup where addicts would be examined from day to day, week to week, time to time, to see what the doctors think the addicts needs.

Dr. MACLEAN: Nods head.

Mr. LIEFF: Supposing now that there is disagreement as to the addicts needs, would there be an unlimited supply for the addict, at his request?

Dr. MACLEAN: No, certainly not. I don't claim to have all the answers as to the way these clinics should be set up. It's going to require an awful lot of study by experts, but I certainly feel there is—it is able to be determined how much of the drug an addict will need in order that he may cope with his job or with his daily stresses and strains. He should be given the opportunity to see whether or not he can work out the problem in that way. If he finds that he cannot get by with what the group of doctors feel that he should have, and if he should then turn to the illegal market, if there is one, then he should be punished unmercifully.

Senator HORNER: You don't believe,—you approve of sending him to jail?

Dr. MACLEAN: If he has been given the opportunity first of all to have a legal supply of drugs and he abuses that privilege, then I feel he should be incarcerated.

Mr. LIEFF: Just one further question; I'm sorry, did I interrupt you I'm sorry.

Dr. MACLEAN: I was just going to say, it's a very difficult problem and no solution is an easy solution, but I do feel that these people, if we realize that they are incurable, should be given some opportunity such as this to find out whether or not they can live useful lives with a legal supply before they are incarcerated or sent away to an island or a community of that nature.

The CHAIRMAN: Would you, doctor, have the doctors administer the drugs or would you just have the doctors supervise and hand out the drug?

Dr. MACLEAN: Never hand it out.

Senator HODGES: I would like to ask the doctor one question there. Doctor, do you consider it consummate with medical ethics to perpetuate a habit in a man which you yourself know is a bad one, by giving him legal drugs in preference to taking curative measures. For instance, I mean, you have a lot to say about alcoholics—would you treat an alcoholic by giving him all the free liquor he wants.

Dr. MACLEAN: Certainly not. No.

Senator HODGES: But you don't think that same principle applies to drugs, you're not doing the same thing by suggesting that they have legal nurses through these clinics. I mean, to a lay-mind like myself, I can't see that there is any great deal of difference between the two things.

Dr. MACLEAN: I feel there is a great difference. I feel the chronic addict is, in ninety-nine per cent of cases, absolutely incurable.

Now, we're faced with a problem which is then very difficult. He has an incurable disease. If we do not give him his supply of drugs, legally, then he is going to get it illegally. How, then, can we compete with these illegal racketeers? We will perpetuate this illegal traffic in that manner.

Senator STAMBAUGH: All addicts are practically chronic in a very short time, aren't they? In a matter of a few months?

Senator HORNER: Doctor Stevenson believes that they could be withdrawn and could be cured, as I understood.

The CHAIRMAN: That was his evidence this morning.

Senator STAMBAUGH: Do you think there are any large percentage of doctors that agree with you that in giving it in small doses—most of them we have heard believe the best way to do is to cut them right off.

Dr. MACLEAN: Is that a cure?

Senator STAMBAUGH: Well, if you take it out of their system one way or the other the effect is the same, isn't it? You would prolong it over five or six months and they would do it in five or six days.

Senator HODGES: But your idea, doctor, is not to cut it off at all?

Dr. MACLEAN: No I'm not saying it should be cut off at all.

Senator HODGES: That's my point. You aren't prepared—

Senator STAMBAUGH: Never entirely cut off.

Senator HODGES: You are prepared to give it to them for as long as they—

Dr. MACLEAN: Live.

Senator HODGES: Yes, that's the point.

Dr. MACLEAN: My feeling is that your youngest chronic addict, we'll say today is twenty years of age. Now, let us accept the fact we have five thousand of these addicts. We've got to do something with them. My feeling is, the best thing to do is to give them their drugs until the youngest of them has passed away but, at the same time, take your steps to prevent a new addict population.

Senators HODGES: How are you going to prevent it, doctor, if you're giving free drugs to these people—young people for instance—who probably tell others of it. Don't you think you're going to create new addicts, just out of sheer curiosity among your young people?

Dr. MACLEAN: Well, we're not going to give—we're going to set up a date, we'll say, by which time every addict must register themselves. Beyond that we will not take any new addicts.

Senator HODGES: No, but you set up a date, say, for the sake of argument, September. Are you pretty sure that by the time September comes that there won't be more addicts formed just out of sheer curiosity for a new experience among young people?

Dr. MACLEAN: You mean after that date?

Senator HODGES: Or before that date, with the idea of getting free drugs. Knowing that curiosity is the thing that stimulates so many of these young people to try these things. I'm merely asking your point of view as a medical man, whether you think that—

Dr. MACLEAN: I don't think that would be any influence to start.

Senator HORNER: You didn't recommend free drugs?

Dr. MACLEAN: Not necessarily free, but where they could get them at cost.

Senator HORNER: Legally.

Dr. MACLEAN: Legally.

Senator LÉGER: Are you in favor of a clinic?

Dr. MACLEAN: What do you mean by a clinic?

Senator LÉGER: Places where they could go and get their drugs.

Dr. MACLEAN: Distribution centres, yes.

Senator LÉGER: You believe in that. The drugs should be administered by a doctor.

Senator STAMBAUGH: They would have to have a prescription, is that the idea?

Dr. MACLEAN: Well, those are details I think, probably, which would have to be worked out when the time came. There are many different ways and means of giving the drugs. I know when we did it in my office, originally we had them come in twice a day, early in the morning (eight o'clock, I believe) and eight o'clock in the evening.

The CHAIRMAN: Even then you had failures, doctor. But I was going to ask you, what was wrong with the experiment in the U.S., where they were trying out and advocating giving drugs under doctors' prescription. They brought them from all over the country and it rather increased drug addiction rather than solve it.

Dr. MACLEAN: Well, in the first place, I believe, from what I've heard, they gave the addicts the drugs to take themselves. Secondly, you must remember, I am not only advocating this phase, but at the same time, a markedly increased penalties to prevent this illicit traffic from that point on. Possibly the legal side wasn't taken into consideration in the United States at that time, and I think if we didn't change our criminal code here we'd run into the same difficulty.

Senator HODGES: Another thing you say, doctor, we should take steps to make sure that the illegal traffic is thoroughly suppressed. How would you take steps? I mean, it seems to me that every step has been taken now, but the very nature of heroin itself is confined in such a small space, it seems to me it would be terrifically difficult to even suppress.

Dr. MACLEAN: What I mean is this. If we were to establish that all present addicts beginning tomorrow could obtain their supply as I outlined then we would have no, shall we say, illegal problem at that particular moment. As of from then, if every person involved in the illegal traffic or using of heroin was, shall we say, given a sentence of twenty years—

Senator HODGES: Ah, but you've got to get them first. The thing is to find them.

Dr. MACLEAN: Very true. But we get them today and they don't get sentences such as that. I mean, when we've given them the opportunity to do it legally, then we can honestly turn around and punish them for doing it illegally,—

Senator HORNER: You have an argument there—

Dr. MACLEAN: —but today we are not giving them the opportunity of doing it legally, we're punishing them because they're doing it illegally of necessity.

Senator BEAUBIEN: Doctor, may I ask this one question? Suppose that you establish this system that you are advocating here, and a drug addict or a man comes in and he wants his drugs, how do you decide whether he is an addict or not? Somebody else might go there. How would you decide that, through medical examination, would you?

Dr. MACLEAN: Oh, yes, we could determine.

Senator HORNER: He might have a registration card. He might have to be forced to carry a card, would he, the drug addict?

Dr. MACLEAN: Oh, yes, there are many, many ways. I think those are details, of course,—

The CHAIRMAN: Doctor, not being facetious or unfair, there is an old adage that says when doctors fall out who is to decide, I'm afraid it will be left to the committee to decide. When doctors fall out, that is, there are different views.

Mr. LIEFF: Would you continue to give the drugs in the way you suggest to an addict who will not work?

Dr. MACLEAN: Yes. You're going to run into this problem. Some of these people are psychopathic personalities. We've found several of them. I'm sure Doctor Stevenson found many too. The type of person who could not fit into society with drugs, without drugs, or in any other way, shape or form. The person who is physically capable to work but possibly, we'll say, is on social assistance and hasn't done a day's work for twenty years. Some of these type of people are drug addicts and they would never work.

Senator STAMBAUGH: Would you lock them up? They're stealing now to get along. What would you do with them?

Dr. MACLEAN: Psychopathic? Give them social assistance, support them, we do with lots of others.

Senator STAMBAUGH: In an institution, or—

Dr. MACLEAN: No, not necessarily, unless they engage in crime after this legal opportunity.

Senator TURGEON: Doctor MacLean, as Senator Hodges has suggested in her questions, you're planning that the number of addicts now, say roughly five thousand, would be the ones under consideration.

Dr. MACLEAN: Yes.

Senator TURGEON: And when they are treated and are finished their stay on life, I gather that you imply that the problem would be more or less solved. Now, we've been told at different times that those who eventually become addicts are not due from any particular craving for drugs, but because their whole surroundings have been bad, their family life has been bad, the juvenile delinquent or anything you like. Now they, then, if that second statement is correct, they would be craving for drugs or something. Now what about that problem?

Senator HOWDEN: Craving is putting it mildly.

The CHAIRMAN: A new crop would come up.

Dr. MACLEAN: I beg your pardon?

The CHAIRMAN: In other words, a new crop would arise with the craving of the former group.

Senator TURGEON: That group would be craving for it. What would happen? Wouldn't something bring about the sale—

Dr. MACLEAN: My experience with these people has been somewhat similar to Doctor Stevenson's, and that is that the young people of today, possibly, let us say for example that a young seventeen or eighteen year old has been caught stealing an automobile. He is sent to Okalla where his cell mate we will say is a narcotic addict. He associates with that narcotic addict for a period of six months. I know that doesn't take place today, there is segregation now, but they did some years ago. So they haven't a great deal to talk about and they talk about drugs, etc. Now, this young man gets out; in his mind is the idea he'd like to try taking narcotic drugs. So, eventually, he either badgers this friend he met or some other acquaintances whom he knows are taking drugs, into arranging that he can have a fix, and so he carries on in that way.

Up until recently, a great many of these people told us that they had their first association with narcotics in jail. Now, I think if drug addiction is legalized, if it's put on the basis of being a chronic illness, if it's treated in clinics, and so forth and so on, it isn't going to have the glamour or the thrill that it has had in the past. And I don't think, probably, young people will turn to it—rather they will use one of the other more socially acceptable things, such as alcohol.

The CHAIRMAN: You don't think, doctor, giving it the look of respectability by the law would not have just the opposite effect?

Senator HODGES: That's the feeling I have.

The CHAIRMAN: You are giving it respectability by making it legal. Then it would be no crime, you see. The one who is using it might go and say to others, oh, I'm getting it legally, you should try it.

Senator HORNER: Doctor, do you—

Dr. MACLEAN: I believe there's a small danger there, certainly. Of course, we're not going to have, we hope, after this is set up, this criminal illegal group where it will be obtainable.

Senator HODGES: My point is, you get young people, you say a young criminal goes into prison and talks to another one and he is told of the wonderful effects of taking the drugs. Well, isn't that going to be increased a thousand fold if you give it free or practically for nothing. Aren't they going to talk just as much of the exhilarating, stimulating effect of these drugs and so encourage others to do it?

Dr. MACLEAN: I don't really believe that the addict tells the other person about the exhilarating effects.

Senator HODGES: Well, what is it that causes the young person in jail to—

Dr. MACLEAN: Simply curiosity, I think.

Senator HODGES: Well, that's the point. Don't you think—that's the point I tried to make before—don't you think that youthful curiosity will be even more avid in a situation of that kind?

Dr. MACLEAN: Where are they going to come in contact now with that?

Senator HODGES: In every day life. They won't have to go to jail for it. If you legalize the distribution of drugs.

Dr. MACLEAN: Well, we hope these people aren't going to be down in the underworld and so forth and so on.

Senator HODGES: Yes—

Senator HORNER: Might I ask, doctor, what is your opinion of the number of people through painful accidents and painful illness are administered the drug until they become addicts. Do you think there is any formed in that way? Any addicts?

Dr. MACLEAN: Not of any significance, no. When a person is taking a drug for a reason, or for pain, he doesn't become so readily addicted.

Mr. LIEFF: Doctor, do I follow you, are you going to take the present number of five thousand, just freeze it at that, and let them look after themselves until they die out and that's it—that's the way we solve the problem.

Dr. MACLEAN: You must remember, I proposed other ideas here as well as that, and I want to make that very clear. There has been too much misinterpretation in my belief, for example, of this Community Chest effort. Everybody says, oh, that's where you are going to give free drugs to all addicts, that sort of idea, but there is a lot of good, sound information, I think, in that report, other than that.

Senator HODGES: I don't think anyone is criticizing that, doctor. I think it's just that we're trying to get at your ideas in connection with that.

Senator GERSHAW: Would you not be afraid, doctor, that those dispensaries would simply be an additional source of supply for the addicts and that they would take what they could get there and if they feel they need a little more and that would create a demand which would ultimately be met by some pusher or supplier. Would you not be afraid of that?

Dr. MACLEAN: I think that is a possibility, if these distribution centres and if our laws are not changed to cope with the situation. In other words, I have heard it recommended that we should incarcerate all these people for ever and a day, that we should put them away on islands and so forth and so on. I think probably I would almost agree with that, or could almost agree with that, after these people have been given the opportunity, first of all, of leading a reasonably normal life and getting their drugs legally. I couldn't believe that now.

Senator HODGES: Would you do that for the protection of the public or for the protection of the addicts themselves.

Dr. MACLEAN: Which, Mrs. Hodges.

Senator HODGES: To incarcerate them, put them away on an island. I mean do you consider that would be for the protection of the public?

Dr. MACLEAN: Economically, yes.

Senator HOWDEN: Doctor MacLean, I believe there are two types of addicts, some of which wish honest to God they could get away from the drug. If you have the cooperation of those people, then you can cure them. I know you can cure them! Because I am a medical man and I know it. They can be cured, but you can never cure confirmed addicts because he'll get back to the drug no matter how ever often you try in a hospital. The only thing to do with that fellow is to put him on an island and keep him there. And perhaps after he has been there ten or fifteen years he won't take any more drugs. What?

An Hon. SENATOR: He might be dead.

Senator HOWDEN: He might be dead. Well, he's better dead.

The CHAIRMAN: One of the questions, doctor, that's puzzling me, at the beginning of this enquiry, you mention leading a "normal life". I'm thinking of the great number of addicts who since childhood are criminals, and have lived the life of crime, perhaps alcoholism and they take to drugs, I'm wondering how, when you say you cure them of drugs, that they are living a normal life, what kind of normal life would a man who has lived the criminal life—what would he become, just simply by dropping the drugs. You have two phases of a man's life there.

Senator HOWDEN: I think you are pre-supposing too much. I don't think there are half so many criminals who are addicts as you think.

Mr. LIEFF: Mr. Chairman, gentlemen, I don't want to break in but we are at ten minutes to four. We have arranged to hear Magistrate Orr and the representative of the Salvation Army this afternoon. I don't know when we'll get them in if we don't hear them today.

The CHAIRMAN: We do appreciate the doctor coming and on behalf of this committee I wish to thank you most sincerely, for taking the time.

Senior Major John Steele of the Salvation Army, may I greet you, sir, on behalf of the committee.

Mr. LIEFF: Mr. Chairman, and gentlemen. One wearing that uniform doesn't need an introduction to this committee. It is obvious that this witness is interested in the rehabilitation of men and perhaps we could leave the introduction at that.

Major STEELE: I am the Public Relations officer of the Salvation Army. Captain Leslie is here with me at this hearing and he is the officer in charge of our Harbour Light Centre, which deals with men in the Skid Road area. We also have with us Brigadier Hector Nyrerod who is our prison and police court officer who attends city jail daily, Oakalla and New Westminster penitentiary. These two officers are standing by and I have been delegated to read to you this statement in response to the request to appear before this committee, as the voice of the Salvation Army. I do so, sir, as the Public Relations officer.

Senator STAMBAUGH: Have you further copies of that, please?

Major STEELE: I am very sorry, I was not advised that I was to have them, and as soon as I entered the room I saw my error but I didn't foresee the need of it and I only have one copy in my hand and I believe the secretary has another.

Senator HODGES: Would it be possible to get copies afterwards?

Major STEELE: I shall be very pleased to provide them.

Senator BEAUBIEN: It will be printed in the record.

The CHAIRMAN: Proceed, sir.

Major STEELE: Social service for men as conducted by the Salvation Army is the direct outcome of the social scheme of the Founder, William Booth, which was presented to the public in his book, "Darkest England and the Way Out", published in 1890. His remarkable foresight in dealing with the welfare problems is testified to by the fact that reprint editions have been necessary as this book has been continually in use since first issued as a reference text book among professional social workers and welfare agencies.

The primary function of the Salvation Army Men's Social Service Centres is the moral, mental, physical, social and spiritual rehabilitation of men. It provides the men who, having lost grip on himself, has become incapable of functioning as a reasonably adequate and self-supporting citizen, with the opportunity to regain a measure of self-mastery, and to acquire such moral and spiritual principles of conduct and habits of industry as will enable him to take his rightful place in society.

The Salvation Army welcomes this opportunity to make this contribution before this Senate Committee in its study of the serious social problem of drug addiction. For over seventy years our Officers have been at work in the skid-rows and prisons of the world's great cities, in daily contact with human derelicts who sometimes are spoken of as the very dregs of society. Regarding these debased, weak-willed, vicious, alcoholics and slaves to the disease of drug addiction, we labor under no delusion that a utopia can be introduced by any social welfare program alone. In the struggle of life the weakest go to the wall, and there are thousands who are weak. What we can do is to alleviate the lot of the unfit, and make their suffering less horrible than it is at present. However, no amount of social assistance will give a jellyfish a backbone. No external propping will make a man stand erect. All material help from without is useful only insofar as it develops moral strength within, and some men seem to have lost even the very faculty of self help. There is an immense lack of common sense and of vital energy among many men. But how can we wonder at the lack of common sense on the part of those who have had no advantages in life, the illiterate, the uncouth and the moron, when we also see an absence of sense amongst many who have had all the advantages of life.

Everything that the Salvation Army does is governed by the principle that there is no complete solution to social reformation of the individual other than the bringing of a new moral life into the soul of these people. To get a

man fully reclaimed it is not enough to give a man clothing, shelter, food, medical care or even a University education. These things are all outside of a man, and, if the inside remains unchanged your labor will be largely, if not completely, lost.

I wonder if I may have a drink of water, sir?

There must be grafted into the man's nature a new nature which has in it the element of the Divine.

This statement, sir, is endorsed by the following testimonies, in support of what we propose or present as actual facts of restoration.

Ernie found himself enslaved by alcohol. While being treated for this problem in a Sanatorium, and being weaned off it by shots of morphine, Ernie became addicted to drugs. He soon found himself enslaved by this terrible habit, and was absolutely powerless when it came to living without it. Fourteen months ago he found himself in the Vancouver Skidroad, a poor, helpless, hopeless wreck of humanity, a physical, mental and spiritual wreck. Ernie heard about the Harbor Light, and it's program for Addicts and Alcoholics, and came into the service one morning, and after listening to the sincere testimonies of men who had been enslaved by like evils, but who had found deliverance through a sincere faith in God, it was not long until Ernie was found seeking counsel and guidance from the Officers of the Harbor Light Corps, and, like many others, he put his trust in God, and he put his faith into practice. He found that through this simple trust, and the program outlined by Harbor Light, he was soon on his way back up the social ladder, delivered from the habit of drugs and alcohol. Ernie is now taking his place in society, again, and has his own business again in the Okanagan Valley.

Graham bears the scars of many a dirty needle on his arms. The fingers on both hands are crippled from taking the needle so often over a period of years. But all this came to an end when Graham walked through the doors of the Harbor Light, eighteen months ago. He, like so many other men, heard how the power of God could give him release from these habits that had bound their lives, and that evening Graham knelt in prayer and found deliverance from the terrible evil of drug addiction. After eighteen months, Graham has never had to go back to this habit, and he is now taking his place in society, steadily employed, and helping other men to find a new way of life.

George had been an alcoholic for years, but had managed to keep himself clean, and always had a job, even if it was only for a short period of time. His work was always as a hospital orderly. But he worked himself into a responsible position in a hospital where he had access to drugs. He had always heard of the "bang" or "lift" that one could get from narcotics, and after using the needle a few times, George found that he could not do without it. He was soon dismissed from his job, and lost many others after this. Then he found himself stealing and conniving—doing anything to obtain that all important shot. After a period of so many years at this, George began to wonder if there was any permanent release from this problem. He found the answer at the Salvation Army Harbor Light Corps, as he listened to the testimonies given by men who had been enslaved by the same evils. George found deliverance, and he is now on the staff of the Harbor Light, helping other men to find a way of escape.

Charlie had always been able to hold his own as a lawyer in an American city. That is, up until he took his first shot of morphine. Shortly after this, he began to realize that he could no longer hold his own without that all important shot in the arm. After a few years of this kind of living, Charlie soon found himself disbarred from the law, and a helpless drug addict, shuffling the skidroad, trying to make a fast dollar to get that next shot. He entered a

Salvation Army centre, and sought guidance from the Officers in charge, and was told that faith in God, and by the help that he would receive in the Centre, he would soon be on his way back and he so did.

Leo was given up as absolutely hopeless by doctors and psychiatrists and other agencies who tried to help him with his drug problem. He had been at it for years. His arms were knotted and scarred from dirty needles. Was there any hope for him? He found that there was when he came to the centre and through the kind and patient help received there, he found himself able to break his drug habit. He found the rehabilitation helped himself and helped him to help other men.

In consideration of the difficulties with which this committee has to grapple with, we make no appeal either to the emotionalists or to the headlong uninformed enthusiasts who would suggest this or that untried remedy for a long standing vicious habit of drug addiction. The Salvation Army makes no pretense of having diagnosed the physical character of the drug habit or the complete physical program to be carried out to reclaim these men, but it is our sincere hope that the sum total of this investigation will result in early active provision to meet this challenge to society. We would further add that we would stress the urgency of this problem. The presentation of plans which are more or less visionary with regard to reclamation may become incapable of realization for a long time to come. We feel the problem is acute and demands considered action now.

The Salvation Army believes that 90 percent of our vice, crime and other social evils stem from the poisonous tap root of alcoholism. Alcohol and drugs go hand in hand. Sometimes drugs lead to drink and vice versa. A necessary part of the study of drug addiction is the accompanying problem of the alcoholic.

In some parts of the world the Salvation Army operates 'inebriates' colonies. These are segregated places where men go of their own free will, for cure and treatment. Voluntary segregation is the basis of the success of these projects. Men who are kept under guard or lack self-will to conquer their evil habits are not very likely to become reclaimed. Drug addicts and alcoholics kept in involuntary segregation in prison invariably return to their former habits and companions just as soon as released. It is possible that the same result would be evidenced in any compulsory segregation centre regardless of the location.

This is not to suggest an attitude of despair, but we must face the facts that altogether too few show any signs of heart desire to make a fresh start, and we also acknowledge that not many, in comparison to the thousands afflicted, are fully restored spiritually and physically.

The rehabilitation of men through the social work of our organization is a two-fold operation. The first essential is spiritual reclamation, and the second is a work program.

We are at present planning the erection of a workshop centre in Vancouver to extend our program. During the past year over 70,000 attendances have been registered, of men attending our Vancouver Harbour Light Centre. Of this number, over 400 made a fresh start in life through the spiritual and material assistance and guidance given there.

Included in this number of restored men are those who have held leading positions in the professions and industry. Over 35 per cent of these men are young enough to be veterans of the last war. Some of these men are already employed in our Industrial Salvage Centre, and it is our plan to extend these facilities. Not only will this Centre meet a specific need of the Salvation Army but we visualize its value as a workshop to serve as an auxiliary to any official institution by governing bodies for the care of men undergoing medical treatment for the drug habit. We might also add that the provision of free clinics and free drugs is not in our opinion the solution to this problem.

Our Social Service Centres provide an organized opportunity for a man who has failed, to try again. This work leads to his becoming self-supporting while we strive to remove his handicaps. We have one goal—helping a man to face the problems of finding a job through various channels. The Social Service program does not pauperize men, it helps them to help themselves.

All of our measures are hopefully directed to the final establishment of men as good citizens of their community. But no amount of hopefulness can blind our eyes to the fact that some men are helped to their feet only to relapse time and time again. These often become totally incapable of self-control, and as such are a menace as they prey upon society, infect others, and multiply their kind. Such men should be the object of compassionate care, and be segregated without being denied the advantages of moral, mental, and religious influences. Settlement of these men on a remote penal colony is not the complete answer to their problem.

The Republic of France operated the notorious Devil's Island for a century. Criminals, drug addicts, and social outcasts to the number of 70,000 were isolated on the Island. Very few ever returned to their native France. The government of France eventually permitted the Salvation Army to establish its work on Devil's Island and after years of representation to the French Government by our organization the detention colony was finally abolished. When some of these men were finally discharged and made ready to take their places in society again, they were faced with the final obstacle of their social readjustment. The Penal Administration had no interest beyond seeing that the prisoner served his sentence. It made no provision for what might follow and it simply did not envisage the day when a man might be free. Further, a man returning to society would be physically weaker than the average, with a mentality warped by his separation from a normal world. When not apathetic, he could be vicious. The scales were heavily weighted against a successful rehabilitation. We did not hide these difficulties from these men, but so great was their desire to return to their native country that they would not dwell on these problems. The French Minister of Justice stated "one can sentence a prisoner to life imprisonment but our hearts and our feelings and our Christianity, in particular, forbid us to crush a man any lower than he actually is. "After fifty years as a Magistrate," the Minister of Justice stated, "I sum up my convictions in one sentence, 'there is no justice without humanity'. Punishment must have not only deterrent but moral power." The President of France also declared, "the Prison Colony on the Island of Guiana does not appear to have provided them with any means of moral reformation or of rehabilitation."

In summary, the Salvation Army recognizes that all too few of the large number of drug addicts reported to live in Vancouver come, at any time, under its direct influence. Such persons usually do not have the force of character to readily avail themselves of methods for the deliverance from their habits. These men and women are the victims of an expensive habit. Money for their drug purchases is not available on skid row, and food and shelter provided by voluntary agencies does not meet their peculiar physical needs. Our contacts with alcoholics are much more numerous; however, an alcoholic is a potential drug addict, and his reclamation undoubtedly reduces the sum total of drug cases.

It is the hope of the Salvation Army that out of this study will come establishment by governing authorities of adequate facilities for the physical care and residual treatment of drug cases. In addition, after care, a work program directed to their reestablishment should be instituted and work placement secured.

These observations are respectfully submitted to this Committee by the Salvation Army. We are ready to continue our fullest cooperation in public service in assisting towards the removal of social welfare problems, the rehabilitation of men and women and the social betterment of our community.

The CHAIRMAN: I think, sir, and I am sure I voice the opinion of all the Committee, that you are to be complimented on the wonderful work The Salvation Army is doing to rehabilitate these men and women

There is one question, Major, that I would like to ask. You said that drugs lead to drink and drink leads to drug. We were rather of the impression that drug addicts were formerly alcoholics, but I think this is the first time it has come before us that a drug addict will go back to liquor. What experience have you had in that sir?

Major STEELE: Sir, as a Public Relations Officer I am responsible for the official attitudes of the Army in all public relations questions and I have read the paper because of that. May I have the privilege of calling an officer who is—

The CHAIRMAN: It is an interesting point.

Major STEELE: Yes. Would the brigadier and the captain come forward, please?

Captain LESLIE: May I have that question, please?

The CHAIRMAN: The question is, we have been told that drug addicts previously, many of them, were alcoholics, but we heard in the witness's statement today that a drug addict will go back to liquor, and my question is what experience have you to make such a statement.

Captain LESLIE: As to the why and wherefore of why they do it, sir, I couldn't answer that.

Senator HORNER: Have they done that to your knowledge?

Captain LESLIE: Most definitely.

Senator STAMBAUGH: Both ways?

Captain LESLIE: Did you say both ways?

Senator STAMBAUGH: Both ways.

Captain LESLIE: My experience has been both ways, but you see the type of men we deal with at the Harbour Light are mostly alcoholics. For instance, we don't find an actual drug addict in the actual skid road area of our city. An addict, as we read in the paper, has to have so much money to keep going, and keep him supplied with drugs, so you're not going to find him down at the Salvation Army or any other Mission looking for a bowl of soup. But I find in our congregation a good deal of men who at one time were addicts but ended up in the skid row liquor addicts.

Senator TURGEON: Free of drugs?

Captain LESLIE: Free of drugs.

Senator BEAUBIEN: Do I understand that these people probably couldn't find enough money to buy the drugs and went to liquor which is the next thing to it?

Captain LESLIE: Yes.

Senator TURGEON: They were then cured of the drugs?

Captain LESLIE: Pardon me?

Senator TURGEON: They were then cured of the drugs?

Captain LESLIE: They weren't taking it then, at any rate.

Senator STAMBAUGH: Perhaps they weren't able, to get them, I suppose.

The CHAIRMAN: They actually left the drug and took to liquor.

Captain LESLIE: Yes.

Senator HORNER: Perhaps forced to because of lack of funds.

Captain LESLIE: That is right.

The CHAIRMAN: That is a most interesting statement.

Captain LESLIE: Oh, definitely, we have proof of it right there in our Centre every day.

Senator STAMBAUGH: Now, have a very large percentage of alcoholics once been drug addicts?

Captain LESLIE: I won't say a large percentage—a percentage of them.

Senator STAMBAUGH: Large or small?

Captain LESLIE: A small percentage.

The CHAIRMAN: Are these cases quoted really cured?

Captain LESLIE: Yes.

Senator HODGES: The question is would you call that a cure, Mr. Chairman.

The CHAIRMAN: I'm sorry, I was speaking of—he mentioned special cases that have been cured.

Senator HODGES: Oh, I see.

Senator HOWDEN: The way they were cured of the drug habit was that they couldn't find money to procure drugs but they could find the money for whisky.

The CHAIRMAN: He mentioned certain cures in the reading of the paper, people who came in to your association and became cured, who didn't go to alcohol or anything else.

Captain LESLIE: That is right, sir. We have had men who were given up as absolutely hopeless, turned out of institutions and centres right here in this province that medical science couldn't do anything for them, but when they came and put their faith in God these men have been delivered.

Senator TURGEON: And they are getting no treatment for drugs in the meantime?

Captain LESLIE: No treatment, whatsoever. I might mention this, that one of our leading Christian men in the Salvation Army today was given up as absolutely hopeless, he has proof from doctors to show that he was absolutely hopeless; he's been in all kinds of sanatoriums and hospitals being treated for drug addiction and was turned out because there was nothing they could do for him. He came in to one of our Centres. His body was so saturated with drugs that he fell three times coming down to the altar, trying to get to our altar at the front of the church. He just dropped there and prayed and asked for Divine help and he got it that night. That's fifteen years ago and that man last year was—or just two years ago was voted the Chicagoan of the year in the city of Chicago. He's a personal friend of mine so there is—

Senator HODGES: That man had something in his character.

Captain LESLIE: Anything that he ever had in his character was beaten out of him after thirty-five years tramping on the skid row.

Senator LEGER: He came back to faith.

Captain LESLIE: That's right. He came back to faith.

Senator STAMBAUGH: What drug was he addicted to?

Captain LESLIE: Morphine, heroin—Tom would take anything—just anything at all that he could get at. Anything he could get a bang out of and get the money to get it. We're seeing it every day and every week. I've seen men who have come there almost extremely out in agony and pain from trying to get off drugs, but kneeling there in prayer and putting their faith in God, they found that to be the answer to their need.

Now, I'm not saying that that will work for everybody. It will work if they want it to work.

Senator LEGER: That man had faith in his younger days.

Captain LESLIE: More than likely.

Senator LEGER: Then he came back.

Captain LESLIE: Most of us go to Sunday School in our—

The CHAIRMAN: Early training.

Senator LEGER: Yes.

The CHAIRMAN: Any other question you would like to ask? I think the answers cover just about everything. Faith is everything.

Thank you very much. Continue the good work.

Mr. LIEFF: Magistrate Orr.

Magistrate ORR: We don't usually get called. It's usually the other way 'round.

The CHAIRMAN: On behalf of the Committee may I welcome you.

Magistrate ORR: I haven't prepared a brief or anything of that sort. I thought I would just like to give you some information that I have prepared and I also have a letter from the Secretary. I brought some figures with me. I don't want to take up much of your time. I just want to tell you my own background.

I am a member of the Police Commission as well as Police Magistrate of the City of Vancouver. I have been a member of the Bar about thirty-nine years, and all of my professional life I have been connected either with prosecutions or with the office of Magistrate.

I don't claim to have any specialized knowledge of the drug question at all, other than the course of my professional duties, having come in contact with some thousands of cases, either of users or traffickers.

The problem of course is getting bigger every day and one can't be in contact with a large number of cases of that sort without finding out something about it.

In the year 1952 I did (at my own expense, incidentally) visit the Public Health Narcotic Institution in Lexington, but unfortunately I was unlucky enough to be stricken with some local complaint while I was there and I didn't get an opportunity to get as much out of the visit as I should have, had I been in better health, at the time.

During my practice in Vancouver I have seen all the changes in drug addicts over the course of the years ranging from opium smoking, opium drinking, eating, sniffing cocaine, taking morphine—I have seen practical elimination of cocaine as a drug on this—in this locality and I have seen the practical elimination of the use of opium in this locality and then I saw the extremely serious rise of codeine in the early thirties, when almost every young person was taking it, of a certain class, and then I've seen its complete decline. That is, when I say complete, it doesn't mean 100%, but to all practical purposes its decline. Then I've seen the decline of the use of morphine and its replacement by heroin. Heroin, of course, seems to be a more deadly thing and a greater problem than any of those that we have experienced before.

The Federal authorities have been very slow to try any new approach to drug addiction—we are all aware of that. In about fifty years the only remedy has been to put them in jail, take them out and put them in again. Many addicts, after serving long sentences are back within weeks. Even this morning I had to deal with a case of a young man who had just been charged with possession again, told me, I think, he had been out three weeks since his last conviction for drugs or for some other crime.

Now, I don't know whether drug users are sick people or not; I'm not a doctor. But if they are sick people we have been treating them very much like animals. And if they are merely habitual criminals as some other people will allege, then I think that perhaps Mr. Mulligan's idea of perpetual quarantine is not too wide of the mark under the circumstances.

The Judges and Magistrates, of course, have been complaining about this for a long time and I would like to, myself, congratulate the Vancouver Community Chest and Council for the efforts they made to stir up public interest to the point where a sense of urgency was felt and this Committee is one of the indirect results, probably one of the direct results, and then the research being conducted by Dr. Stevenson I think is an absolutely direct result of the efforts of that Committee.

I would like to say one or two other things. I definitely disagree with the suggestion that has been made in the press and before this committee that sixty per cent or any other major percentage of crime in Vancouver is due to drug addiction. You have heard two witnesses this afternoon—one of them probably quoting me, I'm not sure—who mentioned the figure, a large figure for alcoholism, both in its criminal incidence and in other ways, and personally I agree with that, that the use of liquor is a far greater cause of major crime in Vancouver than drugs. Some figures claim that B.C., has the largest percentage of alcoholics of any other Province, but these figures again are not accepted by everyone. But it is a fact, however, that our arrests for drunkenness in Vancouver for last year would be approximately five times the arrests in the City of Winnipeg. Of course, there is a slightly different population but it is a fairly good comparison. However, Winnipeg, in its annual report which I have here from Chief Taft, of the Winnipeg police, which I received last week, indicates that they only had one narcotics case in 1954 as against the hundreds which we have had here.

I have taken the liberty of bringing with me to the Committee the Court list of the Vancouver Police Court for the present month, of cases that I have dealt with and I will give them to the Secretary. Mr. Dohm will bring the other lists that he deals with when he testifies. We are sorry we didn't start to keep this list earlier, but we just started on the first of April when I heard that I was to be asked to come here. We have marked these lists—we have only marked the major crimes—we have marked them with the letter "C" meaning that the person mentioned has had a previous drug conviction, and the letter "D" meaning that the case involves a drug addict or trafficker who may not have had a conviction. Then we have added the letter "L" to those cases where the basic cause of the crime was liquor. We've gotten to the point in Vancouver where we're testing burglars and holdup men on the drunkometer—the apparatus for testing drunkenness—and we're finding that in some cases of people committing holdups and committing burglaries are very much liquored up. In fact, last month I think three men were convicted of a holdup, (pleaded guilty to it) in which they were each tested on the drunkometer and each of them (incidentally, there was a shot fired in that case) showed an alcohol percentage in the blood which would have caused them to be convicted of drunken driving or impaired driving. In fact, one of the men was really a very high percentage and would have been drunk in anybody's dictionary.

In examining these lists that I have produced and will leave with the secretary, you will find that the percentage of major crimes involving drug users is reasonably small—I don't think it's more than 10%, but unfortunately because of the change in the date that I was to appear, I haven't had time to work these out for myself and I wouldn't want you to think that I was underestimating. I would prefer probably if you would have the secretary of your committee work the figure out himself. Some of the names appear more than

once because the cases have been adjourned. But, now, of course, this list which I am going to give you, will only show people who have been arrested. It won't show the character of the people who have committed crimes and haven't been discovered—there are lots of them, of course—it's a fairly good reflection, when the people that the police arrest for crime should be a fairly good reflection of the class of people who commit the crimes.

I understand that the population of the Penitentiary is about six hundred. I'm giving you round figures and Mr. Douglas will no doubt give you other figures, more accurate, but I understand the population of the penitentiary, for drug act offences is about 25%. There's an additional 5% of other criminals in there for other crimes are also drug users or traffickers. So, it would give the population in the penitentiary of about 30% connected with drugs. I think that's fairly accurate. And that leaves 70% of the inmates of the British Columbia penitentiary without any drug association. Okalla will vary. I haven't got the exact figures; you've probably heard them from Doctor Stevenson. I'm not sure whether you did or not. But Mr. Christie, I understand, or Doctor Richmond, will be able to give them to you.

There is one other thing I definitely disagree with these astronomical figures given by the press and some police officers, about this ten million dollars annually stolen in Vancouver by drug addicts. I've often heard these statements and I've often read them, and I've often argued with people about them, and I think the last argument I had was with a well-known drug addict who was trying to persuade me that it was true. He should, of course, know better than I do. As against that I am going to produce to you figures of the total value of all the goods reported stolen in the City of Vancouver in the last six years—the official figures. Now, mind you, I'm dealing with Vancouver but that's the hub of the Universe as far as Canadian drug traffic is concerned, and I think our figure there is as good for anywhere else.

During the past six years, from our annual reports, exclusive of automobiles, the annual loss in goods of all classes that are reported stolen to the police is \$544,000.

Senator HODGES: Is that in Vancouver or greater Vancouver?

Magistrate ORR: Vancouver, the City of Vancouver.

The CHAIRMAN: That is the annual, is it, your Worship?

Magistrate ORR: That is the average for six years, senator. Some years it will go higher and some less, you see, but that is the average.

Now, of course, you know, as I say, that's a far cry from ten million dollars.

The CHAIRMAN: It sure is.

Magistrate ORR: I know that lots of people have goods stolen, I know that much. They have goods stolen and they don't know they're missed for a time and some, in fact, never know. For example, in the fifteen cent stores I have no doubt that many articles could be stolen, the proprietors never miss them. But when you come to imagine that nine and one half million dollars could be stolen in Vancouver and not missed, I just can't believe that Vancouver merchants are such slow-pokes or that their bookkeeping is so bad that they won't miss it.

Senator MCKEEN: That five hundred thousand is all types of theft, not drug—

Magistrate ORR: Excluding automobiles.

Senator MCKEEN: Yes, but not just drug addicts.

Magistrate ORR: Oh, no, that's stolen by everybody, because when a person reports goods stolen he doesn't know whether it's stolen by drug addicts or not. Now,—

Senator HOWDEN: That is a yearly average, \$544,000?

Magistrate ORR: \$544,000 is for the last six years and prior to that, less. Now, other cities have lower than that probably.

There are some factors that I want to deal with this figure because it's so commonly expressed and it just doesn't make sense to a person who starts to analyze it. There are some factors that I want to deal with in that figure and these factors surely couldn't have been taken any account of by the persons who estimated them in that way.

Now, the first thing is that many drug addicts exaggerate their habits. For example, a man caught with a fair amount of drugs will claim that he has a habit requiring ten to fifteen capsules a day. It may be true, or it may not. On the other hand, he may be saying that in order to induce the Court to believe that he is not engaged in peddling but is really getting a large supply for his own use. That has happened twice within the last week in Vancouver. In fact, it happened this morning, where a man said that he was taking, I think, six at a time—six capsules at a time—I don't know whether that's true or not, but I do know that it's a common device used by persons caught with large quantities of drugs, to excuse themselves, and to take themselves out of the category of trafficking or peddling because they know the punishment for large quantities of drugs is going to be harder than a small quantity. If they can persuade the Court that they are using large quantities, so much the better for them.

Now, there's another factor that it seems to me has been lost sight of in all this arithmetic and that is that your figures of inmate populations of the jails show that about five hundred addicts, at least, are in jail all the time. They can't be stealing when they're in jail. And the figure that was assumed was \$2,000.00, I think, if I read the press correctly (and, of course I'm assuming that the press was correct as usual). They used the figure of \$2,000.00.

Senator HODGES: Two thousand dollars?

Magistrate ORR: Two thousand people—addicts, multiplying that by the number, and so on and so on. Well, if five hundred are in jail that reduces the number of addicts available for stealing by 25 per cent. That's 25 per cent off the figure right there.

Now, there is another thing. Many addicts are from time to time—that is, many of the criminal addicts—are from time to time off the habit for periods of years, I say, even years, although generally much less time than that. I heard Captain Leslie and I heard also Major Steele speaking. Some of the people I know, in fact, I shouldn't say some, that would be guessing, but one of them he mentioned I know very well and I have known him for twenty years and he was, at one time, a very fine man, and they do go off drugs sometimes and on to alcohol. Many of them do though, go off the habit for periods even up to a year. Now, I don't suggest that a year is usual, generally it's much less time than that. But they are off and in many cases before the Courts they are able to prove they have been working at useful work for a period of some months anyway. They have their unemployment books to show it, and so on. They've been working at useful and hard work. It doesn't mean that they've reformed but they are out of this number that are doing the stealing.

I think Captain Leslie covered the question about people going from drugs on to alcohol sometimes, not often, but there is a small percentage.

I agree probably too that, as some of the other speakers said today, I don't recall any cases of a reformed addict in the sense of a complete moral and physical reformation, but I have come in contact with several people who have succeeded in getting off drugs for, as I say, varying periods. Within the last month I had a case where a former addict was found supplying, that is, he was supplying, not selling, narcotics to a prostitute who was an

addict. He didn't seem to be acting in any more than a friendly way, he didn't seem to be a dealer, but was merely helping her to get drugs. And even though the drugs in this particular case were administered in his presence, and he had a long record as an addict, it was quite apparent that he didn't partake in the administration of the drugs. An examination of his body revealed no needle marks. Now, this man, of course, had not reformed, but he was certainly off drugs for the time being.

I regret that I have no constructive suggestion to make to this honourable Committee, sir. I don't know what the answer is. I only hope something is done, because up to now nothing has been done, except the last couple of years the research that is being done by Doctor Stevenson, and this Committee. And I certainly welcome any new effort to find a solution.

I trust that what I have said here will not be understood in any way to minimize this terrible situation we have in Vancouver. But I do think it's bad policy to put the thing in a wrong light, to exaggerate it. I think that I shouldn't allow the Committee to go away without, at least, my view that it is a terrible evil; I think it's increasing in spite of probably what our figures show, but I do say that if we look at it in its proper perspective it will be better than getting any wrong ideas about its extent or the persons involved in it.

There has been a good deal in the press lately about 'syndicates this and syndicates that', fighting each other and that probably is true, but we've never run into any concerted effort to push the drug, to sell it to new customers. I will say that there have been cases where an attempt has been made to get new customers in the sense that addicts have. I can recall cases where, in spite of what you may have heard today (I'm not contradicting the witnesses, mind you. I'm just probably adding something that they hadn't heard about), there have been cases where people have induced others to take drugs, especially young people. But it's not wide spread. I think it's fairly well under control in that respect.

However, before I finish, I thought it would be useful, and I thought the Committee might like to hear some of the close relatives of persons afflicted with this terrible habit; that is, to show its impact on family life and I have here in this envelope, which I will give to the secretary, I have here letters from two fathers, a wife, and a sister, each offering to appear before this Committee, providing they can be heard in camera and in the absence of the press.

Now, Mr. Chairman, I think that is all I have to say on the subject. I will leave these figures, these letters, with the secretary, if I may. I don't know if you want to examine them now.

Senator HODGES: Mr. Chairman, may I ask the Magistrate a question before he goes?

What is the average age? Those drug addicts who have come under your jurisdiction, are they young people or what is the average age?

Magistrate ORR: Madam Senator, in general, the juvenile court deals with cases up to eighteen.

Senator HODGES: Oh, yes.

Magistrate ORR: —and unless, very rarely, that a juvenile would become addicted to drugs under that age would be sent before me by the Juvenile Judge.

The age group varies. I think you could get statistics on that. I have had them pretty young and I have had them pretty old. In fact, I brought up some old records but you haven't had time to—

Senator HODGES: But the majority, are the majority young or—

Magistrate ORR: I wouldn't say that.

Senator HODGES: You wouldn't say that.

Magistrate ORR: No. I think Doctor Stevenson would be your very best—

Senator HODGES: Yes. I just wondered whether in your particular court you would know.

Magistrate ORR: No, there are some young and all ages. I dealt with some cases this morning which—a girl was probably twenty, I think the young man said he was twenty-two, twenty-three, and so on, and another one forty.

The CHAIRMAN: Magistrate Orr, with the changes that were made in the Opium and Narcotic Drugs Act last year, do you find any difference in the cases coming before you, had they a splendid effect or—

Magistrate ORR: Well, the answer to that is, so far, the only cases of trafficking (I may say that I switched with Mr. Dohm in February of this year. He had been taking the drug cases before that, and I switched with him) I've had since that, they have been preliminary enquiries. I haven't had the trials, I've just had the preliminary enquiries and it would be hard to say whether they—what the effect is yet, do you understand? Because the sentences in most cases haven't all come down. But I would imagine anything along that line would be good.

Senator HODGES: You think it would have a deterrent effect—

Magistrate ORR: Oh, certainly,—

Senator HODGES: —harsher punishment and longer sentences?

Magistrate ORR: On traffickers?

Senator HODGES: Yes.

Magistrate ORR: Oh, I think so. The difficulty, of course, is this. We always speak of traffickers, but you heard Doctor Stevenson when he mentioned that the average person who sells it on the street is himself an addict, and it just doesn't sound right to treat him in the same category as the person such as the, well, let's say, the notorious Mallock case. I think it's over, we can talk about it now. That would be in a different category. Whether it would make much difference to an addict himself, I don't know.

Senator HORNER: Would you comment at all on your trip to—what you saw or heard of Lexington, Kentucky?

Magistrate ORR: I would be glad to, sir, but Doctor Stevenson was there after I was there as he would tell you. But I will tell you anything I can. I did think it was a marvelous sort of penitentiary, because I saw the prisoners playing golf and things of that sort.

Senator HODGES: Marvelous sort of club.

The CHAIRMAN: They found a real home, hey?

Magistrate ORR: Well, it sounds that way, but it wasn't. The day I got there I saw a large party of men taking down barbed wire. I thought they were putting it up and when I was discussing affairs with the director, he was more or less putting his best side forward and I said, but I still see you are putting up more barbed wire. No, he said, that gang is taking it down. They were taking it down and they have a very small number of guards compared to the number of—but, of course, it's a combined penitentiary and hospital. Four hundred are prisoners and I think nine hundred were voluntary committals.

Senator HODGES: Are they all together?

Magistrate ORR: They're not treated the same. They're all in the same building, yes. But, of course—I wouldn't like to say for sure—I don't think the prisoners are allowed to go out beyond the wire. I'm not sure about that.

Senator McKEEN: Are the prisoners the golfers?

Magistrate ORR: Well, they're all prisoners in that sense. I wouldn't like to say that. I did see them coming in with golf bags over their shoulders, and their little golf course.

The CHAIRMAN: You had a question, doctor?

Senator HOWDEN: Yes, I have. You are a man of great experience, I appreciate that fact. Now, I have been asking this question today. Have you, to your knowledge, ever encountered reformed addicts?

Magistrate ORR: Reformed addicts?

Senator HOWDEN: Yes.

Magistrate ORR: No, I said so. I already said so in my presentation.

Senator HOWDEN: Yes, I heard you say you thought one man had been off a year.

Magistrate ORR: No, I said that I had never found one who had completely reformed morally and physically to my knowledge, you understand? But I do know of a case—one of the cases that Captain Leslie or the other gentleman from the Salvation Army read out—and there isn't any doubt that that man, up to the present time, is okay. Now, whether he stays or not that's—I think he said eighteen months and I think that's about my own impression of it. I have found lots of people—

Senator HOWDEN: If he wants to be free and he has been freed for eighteen months he'll go on for eighteen years or perhaps eighty years if he lives that long.

Magistrate ORR: He may, I don't know.

Senator HOWDEN: They've got to have the will to be free from addiction, if they're going to get through with their own effort.

The CHAIRMAN: Any other questions, Honourable Senators?

Senator STAMBAUGH: Just for our information, these letters you're leaving, are these from drug addicts or the families?

Magistrate ORR: No, these are not from drug addicts. They're from the parents, wife and sister of drug addicts who have been a great problem to their families, and these people will tell you, if you want to know, the impact of having to live with a member of the family who is a drug addict. If you want them, I'll leave these letters. They are addressed to me—with the secretary—and you can perhaps read them.

The CHAIRMAN: On behalf of our committee I thank you most sincerely, Magistrate Orr.

The committee adjourned until tomorrow, Tuesday, April 19, 1955 at 10.00 a.m.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

VANCOUVER, B.C., Tuesday, April 19, 1955.

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 10:00 a.m.

Senator Reid in the chair.

The CHAIRMAN: Honourable Senators, it is time to commence our proceedings. It is ten o'clock. We have four witnesses this morning and the first one I am going to call upon is Dr. Richmond, the physician at Oakalla Prison Farm.

On behalf of the Committee, I welcome you, doctor.

Dr. R. G. E. RICHMOND: Thank you.

Mr. LIEFF: Dr. Richmond, you are a medical practitioner and have been practising for a good number of years, specializing in psychiatry to some extent?

Dr. RICHMOND: Mostly in prison work, sir.

Mr. LIEFF: Yes, and at the moment you are in charge of the medical and psychiatric treatment at the Oakalla prison?

Dr. RICHMOND: Yes, but we are not yet able to do much in the way of psychiatric treatment.

Mr. LIEFF: And you have a paper? I think we have copies of your paper, haven't we?

Dr. RICHMOND: I hope so.

The CHAIRMAN: Proceed, doctor.

Dr. RICHMOND: May I proceed through this brief, sir, and then we'll have questions if you wish.

The following observations are based on experience of medical care of delinquent drug addicts, male and female, at Oakalla Prison Farm from August, 1952 to April, 1955. I have also had whole time medical care of non-addict delinquents in English prisons and borstals from 1930 to 1940. In Canada from 1949 to 1952, I was a psychiatrist in the Child Guidance Clinic in Vancouver. In addition to duties at Oakalla, I am Medical Officer at New Haven Borstal Institution.

Addiction and Delinquency: The background appears to be similar between addicted and non-addicted delinquents. It is not possible in my opinion to discover any significant difference in the earlier environment of both of these categories of individuals.

It is thought that apart from the more pronounced personality disorder which takes place after the individual becomes addicted, that on the whole, the group of addicted delinquents represents a cross section of the community similar to that shown by the non-addicted delinquents. I would like to add there that when I refer to a "pronounced personality disorder taking place after the individual becomes addicted", I regard that as an acquired state rather than as one which is permanently established. That it is the result of the habit rather than an actual change.

Some super-added manifestations following addiction, are increased dependence of the individual on other people and marked aversion to work which seems to be shown by many.

There seems to be a cancerous invasion of the moral structures, specifically related to the addiction, with absence of ethics, scruples and even the minimum demand of human decency in the attempt to obtain drugs. I would like to emphasize here, sir, that it is specifically related to the drug taking and not a general observation as to their character.

There is entire lack of control in relation to the urge for drugs. There is a very close link between addicts. There is an inability to face situations, a flight and escapism. In many there is a gross egocentricity, which is perhaps not solely the feature of addicted delinquents. It may be shown by others as seriously delinquent but not addicted. There appears to be a lack of trust in counsellors with a strong tendency to use them as a means towards some generous alleviation of their (the addict's) plight. When compulsorily away from drugs, many addicted delinquents express a desire for treatment, but not when they are speaking as a group.

Many addicts show some benign qualities in their personality with sometimes a remarkable degree of understanding and insight concerning general situations, in marked contrast to their inadequacy to curb their overwhelming impulse. In the Witness's experience, the addicted delinquent needs rigid limits imposed on his many indulgences as evidenced during imprisonment, more especially in the way of lack of acceptance, by authority, of excuses tendered to avoid work and other discomforts.

Whatever is offered to many addicted delinquents in the form of attention is regarded mainly as a means to obtain more. As far as sedation, of any type, is concerned, it has to be almost eliminated, otherwise the addicted delinquent becomes even more disturbed, craving and pleading for more and more. The addicted delinquent seems to prosper under firmness and appreciates it.

In regard to delinquency and drug addiction, I am particularly interested in the widely differing situations between prisons in England and Okalla Prison Farm. During the ten years service in English prisons, which included medical duties in a prison of some fifteen hundred inmates, I did not meet one drug addict. The Witness does not consider this to be due to legal tolerance of drug taking and he supposes that Dr. Stevenson has already stated the practice of registration of drug addicts in England and this does not entail any authorized continuation of maintenance dosage of narcotics.

Why drug addiction may appear a specific problem: Contagion: The danger of this seems to the Witness to be a demonstrable reality. A person vulnerable to this habit is sometimes established in his addiction by addicts, although some of the older addicts will warn younger people of the danger involved in drug addiction.

The need to isolate from sources of narcotics: This appears to the Witness to be a necessary procedure, although under strictly isolated conditions some narcotics may penetrate even the densest barriers. Especially during withdrawal treatment a relapse to resuming the habit causes considerable confusion in treatment. A resumption of the prisoner's drug habit may occur when he temporarily leaves the prison, on bail for example.

I believe it to be essential that there should be a completely segregated unit for withdrawal treatment. After much experimentation in the use of non-narcotic drugs for withdrawal, which has included various barbiturates and the more recently developed substances such as chlorpromazine and extracts from rauwolfia, it has been the Witness's experience that the most satisfactory withdrawal is obtained by injection of Sodium Luminal (a copy

of the withdrawal sheet is attached to your brief). It will be seen that the patient for the first 24 hour period is given four grains of Sodium Luminal four hourly, by injection, and for the next 24 hours two grains four hourly. On the first day, the treatment is reduced to two grains eight hourly, followed by the fourth and fifth day sedation of two grains at bedtime. This is for the male. It has been evident that women do not require, in prison, so much medication for their withdrawal, often two or three injections of two grains Sodium Luminal will suffice. This appears to me to be partly because the women are able to obtain more nursing attention and partly because their ceiling of endurance is higher than that of men. Other medication, such as Vitamin "B" tablets, is given. For the few cases which show excessive vomiting, administration of a dramamine medication may be substituted in addition. (Vitamin "B" tablets are issued as a routine). In severe cases of collapse and undernourishment, intravenous feeding is carried out. A helpful relief is a frequent hot bath. Under this regime the withdrawal is complete in five days; this may be partly because a rigid limit is set for the time to be spent on withdrawal but the fact remains that the major symptoms have subsided at that time, and it is possible for the inmate to join the programme of the jail.

Intractibility: The specific demand in the case of long term drug addiction treatment renders it a matter for a special establishment, in my opinion, although it must be borne in mind that the more serious behaviour disorders, apart from drug addiction, require similar length of treatment. In both these instances, even under the most skilled long term treatment, the prognosis is often poor.

Treatment of the Delinquent Addict: A separate establishment for the treatment of the delinquent drug addict in such a locality and with such precautions that the illegal entry of drugs is prevented, as far as is humanly possible is recommended. During the latter stages of treatment, it would be wise to establish a Unit as a transition centre which could be close to the general community.

It is submitted here that there should be legal provision for treatment and confinement of the delinquent drug addict over a number of years. This would require a statutory recognition that using narcotics comes within the Criminal Code or within a Mental Health Act. I believe that the majority of addicted delinquents who have come under my care have been primarily delinquent and secondarily drug addicts. This, therefore, in my opinion, entails the treatment of the delinquency as an essential part of the whole problem. Whatever authority is delegated to carry out the treatment of the delinquent addict, therefore, should be one who is especially qualified to treat delinquency, assuming that delinquency with drug addiction and serious delinquency without drug addiction require the same intensity and type of treatment and training. But with the proviso that the delinquent addict requires a separate establishment, as already mentioned, and a means for committal to it. A suggestion is that any individual who has been proven to be a user of narcotics should be committed to an appropriate centre in which he could be detained for a maximum period of five years, but at any time he can be placed under expert supervision on parole. I would suggest that supervision of the drug addict at large is one of the most problematical responsibilities that any worker can undertake and that the individuals intrusted with the supervision should be exceptional people. This in most cases would require a stay in a treatment hostel for a period decided by the treatment directors—that is whilst they are on parole—from which he could go to work and to recreation; finally it is hoped he would live under normal conditions, but still under supervision.

It might be necessary to work in co-operation with a psychiatric out-patient department in a certain number of cases. It is no doubt the general opinion that without the co-operating function of the employer and employment agencies, any after-care is abortive.

I would desire to stress my opinion that prevention of such a serious sociological problem rests in the same category as that of prevention of all forms of delinquency. This embraces cultural standards and disciplines, secular and religious education, secure home life, abundant and suitable employment, with early diagnosis and treatment of maladjustment and any form of personality disturbances.

Mr. LIEFF: Doctor, I see that you have appended to this paper that you have just given us another document called "Withdrawal Routine". Would you care to make some further comment on that? (*See Appendix I.*)

Dr. RICHMOND: It is a sheet to try to organize the dosage of routine injections in order that,—it should be sure that each patient gets what is allotted to him and is recorded here.

Mr. LIEFF: Doctor, this is a new set-up at the prison, made by you?

Dr. RICHMOND: Yes.

The CHAIRMAN: Doctor, would you care to enlarge on your experience in the British prisons?

Dr. RICHMOND: The experience is conspicuous by its absence in the form of drug addicts. There is a different,—or there was, until 1940, a different feeling, I think I am aware of, as regards sedation of any sort, even among non-addicted delinquents there, we did not get the call for night sedation that we get here. That is to say, the minor sedation in the form of barbiturates. It just seems that it wasn't in that pattern, to any extent.

Senator HODGES: I would like to ask the doctor if he can give any reason why there is so little drug addiction in Britain as compared to Canada, considering the huge difference in the population?

Dr. RICHMOND: I have thought so deeply about this and the answers that I can give I am afraid sound rather vague, but I feel that tradition, cultural standards and perhaps discipline during childhood enter into it to some extent. The tradition that "it just isn't done" in a way I think dies very hard in people.

The CHAIRMAN: Has any study been made of the racial origin of the addicts here. You have brought up the point about the compositions of the people in Britain compared to here. I was wondering if any—

Dr. RICHMOND: I imagine, sir, it is more homogenous now, after so many centuries in England. I don't know if Doctor Stevenson was able to enlighten you over the racial origins here. I feel sure, without scientific evidence, that they are more mixed here.

Senator HOWDEN: I am a medical man too. I would like to ask if, in the course of your treatments, you had made recurrence to hyoscine in the treatment of these patients.

Dr. RICHMOND: We have not used it, sir.

Senator HOWDEN: You have not used it?

Dr. RICHMOND: No.

Senator HOWDEN: Well, I have used it a number of times with very much better effects than barbiturates, because you go from morphine to a barbiturate habit, which is just about as strong as a morphine habit.

Dr. RICHMOND: Yes.

Senator HOWDEN: And the hyoscine doesn't leave any sting of that kind behind it.

Dr. RICHMOND: We find that with firmness, we do not have a barbiturate habit resulting from the withdrawal. They know that is the end. I agree with you that if we weren't rigid over it there would be a hang-over, or a barbiturate habit.

Senator HOWDEN: I have found repeatedly that the barbiturates leave nearly as bad a habit as the opiates, but it has the advantage that there is no desire for the barbiturate the following day. There is that big difference. But the hyoscine to is infinitely preferable and there was nothing left behind at all.

Dr. RICHMOND: No.

Senator HOWDEN: It was a little harder on the heart, but that's all.

Dr. RICHMOND: Yes.

Senator HODGES: Doctor, may I ask what is your reaction, if you care to comment, on this suggestion that has been advanced once or twice, for dispensaries where drug addicts could get drugs either free or at a considerably reduced cost from what they get them now.

Dr. RICHMOND: As I speak purely from observation of people in confinement, I would be afraid of it, because I know there seems to be no limit to their demands once you show any sign of indulgence or accommodations to them, and, I am assuming that might happen outside prison as well.

Senator HODGES: I take it from the general tenure of your paper that you are in agreement with the suggestion that has been made that they should be placed in an isolated—confined in an institution which is isolated from general centres of population and given long term treatment.

Dr. RICHMOND: Yes, isolated as long as the treatment experts think necessary.

Senator HOWDEN: And during that time you would make their surroundings as congenial as possible.

Dr. RICHMOND: Yes. I am assuming that there would be a highly progressive treatment unit.

Senator HOWDEN: Yes, exactly.

Senator GERSHAW: Do you think the five year maximum is long enough for the average case? You speak of a five year maximum in an appropriate centre.

Dr. RICHMOND: I wondered considerably about that, but I felt that at the beginning, it would be more humane to try that length of period rather than a longer one and see if it was sufficient.

Senator GERSHAW: Would you have them working—producing food, vegetables, things of that kind?

Dr. RICHMOND: I would make it as constructive and positive as possible, keep them busy every hour of the day.

Senator GERSHAW: Could an institution like that be anywhere near self-supporting?

Dr. RICHMOND: It should be, sir. I have no knowledge of administration of that sort.

Senator HOWDEN: I think it should not only be self-supporting but afford a little bit of earnings.

Senator HODGES: I don't know. Judging by our experience of other public institutions which have farms and produce things, they are anything but self-supporting.

Mr. LIEFF: Just one question, doctor. I wonder if you would tell the Committee if we would have any difficulty in obtaining a staff in Canada both for the institution, or for the after-care that you mentioned, a trained staff?

Dr. RICHMOND: Sir, the difficulty would be overcome if they were paid sufficiently well to attract experienced people. The strain, the tension, in such a situation would be considerable and I think it would deserve almost professional pay. I don't think you would find any difficulty then.

Mr. LIEFF: It would be a question of just offering people who are engaged in that sort of thing somewhere else more money than they are getting now.

Dr. RICHMOND: I feel so, sir.

Senator HORNER: Doctor, have you any knowledge of any drug being allowed into Oakalla jail not through illegal channels being surreptitiously slipped in there to the inmates?

Dr. RICHMOND: I think it's unavoidable entirely. The amount is reduced to an absolute minimum, I think, now.

Senator HORNER: But it has happened?

Dr. RICHMOND: It has happened.

The CHAIRMAN: Have you any other questions, you would like to ask Dr. Richmond?

Senator HODGES: One thing I'd like to ask. Do you find many recidivists among the drug addicts in your experience in the prison? Have you met with many?

Dr. RICHMOND: Quite a number.

Senator HODGES: You find there are more recidivists among the drug addicts than among the ordinary, normal prisoner?

Dr. RICHMOND: You mean recidivists in the drug habit or other forms of delinquents.

Senator HODGES: No, no, in criminals—in crime.

Dr. RICHMOND: No, I would say that there is not that amount of difference.

Senator HODGES: There isn't?

Dr. RICHMOND: No.

The CHAIRMAN: Doctor, what is the fundamental difference between curing a man of a drug addiction and keeping him off the drug for eight years as they do in the penitentiary here. He has had no drugs at all for eight years and presumably is all cured. What is the fundamental difference between the two systems?

Dr. RICHMOND: The man with the eight years is likely to return to it the moment he leaves—

The CHAIRMAN: Yes.

Dr. RICHMOND: The other would be a basic change of attitude, with an adjustment towards controlling the urge when he has it in hand.

The CHAIRMAN: You think it is all important, that change of attitude?

Dr. RICHMOND: Oh, yes.

Senator HOWDEN: I think you have answered that question very much by saying that one is a patient and the other is a prisoner.

Senator HODGES: You're implying then that the mere abstention from drugs for eight years isn't sufficient to cure a man or woman of the habit?

Dr. RICHMOND: No.

Senator HODGES: It has got to be combined with treatment?

Dr. RICHMOND: Surely.

Senator STAMBAUGH: It would have to be compulsory in both cases, wouldn't it?

Dr. RICHMOND: I think so, sir.

Senator LEGER: Would you think that there would be some cases that would be incurable?

Dr. RICHMOND: Yes. Some of them would never be cured, some of them.

The CHAIRMAN: What I am trying to get clear in my mind, doctor,—a man who has been a criminal all his life, from the age of twelve or fourteen, and up, as many are, incorrigible, he becomes a drug addict, and you take him in under this system and you cure him of drug addiction. Would it make him a completely reformed man who would become moral living and good living after all that length of time? I'm trying to get the picture clear. You see, you might clear him of the drugs but he might start something else.

Dr. RICHMOND: That is, sir, what I was trying to emphasize, that it is a comprehensive picture, that the only essential difference in the treatment of serious disturbances in the drug addict is that you have got to keep him away for the reasons I gave, in my opinion. No, I think that the whole situation needs attention and treatment, not just addiction.

The CHAIRMAN: We have got to go further with the treatment than just mere drug treatment.

Dr. RICHMOND: Yes.

Senator McKEEN: Wouldn't the main difference be, in one case the man wants to be cured and doesn't want to take it again, and the other case the man wants it but can't get it, and as soon as he gets out he gets it.

Dr. RICHMOND: Yes.

Senator McKEEN: That would be your fundamental difference, I think.

Mr. LIEFF: Witness, I wonder if I could discuss with you the addict who just made up his mind, that he is just never going to quit. There must be a hard core of old addicts who could possibly get along on very little. What would you do with a group who would say to you, well, now, if you could give me a shot or so a day, I've got a bit of a job and I'll stay on it now, if I don't stay on the job don't give me any more. What would you do with a hard core like that, or with that sort of a suggestion?

Senator HOWDEN: Those kind of people don't occur. You'll never get them satisfied with a shot a day.

Mr. LIEFF: First of all, are there people like that?

Dr. RICHMOND: I think there is a small number, sir. But I think that the difficulty is that of segregating that small number for that form of treatment, I think that it's not realistic to do so. The dividing line is so slender that you'd have the problem on your shoulders of everybody, before long, wanting the same sort of treatment.

Mr. LIEFF: Wouldn't they just divide themselves? If he doesn't work, doesn't stay useful, he is back with the other crowd again, with the criminal crowd. Wouldn't that sound plausible from the point of view of the old addict?

Senator HOWDEN: Not to a doctor.

Dr. RICHMOND: No, I don't think it would be practical.

Mr. LIEFF: You don't think it would be practical?

Dr. RICHMOND: No.

Mr. LIEFF: We hear that sort of thing from them once in a while, you see.

Senator HORNER: Doctor, in your brief you say they were delinquents first. In other words, do you agree that the taking of drugs doesn't fundamentally change a person's character to any great extent?

Dr. RICHMOND: No. I would agree though that there is the general basic disturbance of which drug addiction is a symptom.

Senator HORNER: But it existed before the drug addiction was—

Dr. RICHMOND: Yes.

The CHAIRMAN: In other words, you might have to go further than just cure an addict.

Dr. RICHMOND: Yes.

Senator HOWDEN: You can never cure a man who doesn't want to be cured, unless you use up endless time and put him where he simply can't come in contact with the drug. God knows it has been made manifest to hundreds of thousands of doctors by this time.

The CHAIRMAN: So that, doctor (Howden), you might under this system proposed by Dr. Richmond have a great number who might attempt to cure but whose mentality—

Senator HOWDEN: You would cure a great many of them, because a man has such a terrible fear of being without the drug that he would be glad to get rid of that—he would accept any condition so long as he was going to be freed of his appetite of the drug. There's no question about that. I'm an old man and I know it. But there are those fellows such as our friend Mr. Lieff down there was talking about who would plead for one shot a day. Well, they would never be satisfied with one shot a day, never in the world.

Senator HODGES: You have got to take it away from them altogether.

Senator HOWDEN: Take it away from them altogether.

Senator KING: Doctor, you seem to be of the opinion that most of these people can be cured if they are retained long enough under supervision. The majority would be cured, I take it.

Dr. RICHMOND: I would not go as far as to infer that at all. I wouldn't like to dismiss it as summarily as that. I have fears of a graver sort, but I think that we should try and see what could be done on a long term treatment basis.

The CHAIRMAN: Any other questions? Doctor, we thank you very much indeed.

Dr. RICHMOND: Thank you.

The CHAIRMAN: Mr. Christie, would you kindly come forward? On behalf of the Committee I welcome you.

Mr. Christie, Warden of Oakalla Prison Farm is our next witness.

Mr. CHRISTIE: I would like to commence my comments by saying that I have some doubts about the necessity of my appearing before this committee, because, in Oakalla, we work as a team, and whatever I think or would say would be a repetition of what Dr. Richmond has already said.

I heartily endorse, first of all, what you have just heard from him, as far as myself as the Administrator is concerned.

I could sum up my comments concerning addiction which stem from fifteen years of institution work, by some very brief comments which are as follows:

1. Addicts are pretty much the same as any other delinquent or maladjusted person we have to deal with. If there is a difference in the problem it's only a difference of degree. Fundamentally the addiction is a symptom which is super-imposed over other personality faults. Therefore, to treat the addict you have to treat the basic faults also found in other maladjusted personalities.

2. Addicts can be successfully treated,—

Senator HOWDEN: hear, hear.

Mr. CHRISTIE: —in the same manner in which we deal with other personality problems. Since the addict is pretty much the same as other people with personality problems, he can be treated in the same way.

Senator KING: Can he be cured, though?

Mr. CHRISTIE: He can be treated and he can be cured, yes. I'll deal with that at greater length later if you wish.

Senator LEGER: Not all of them.

Mr. CHRISTIE: I'll deal with that at greater length also.

3. Treatment of addicts at certain stages requires control. Treatment of some types of personality problems can be dealt with on probation, and in very permissive ways. However, the majority of addicts—not all addicts—but the majority require control as a part of treatment; a type of control which is most commonly associated with institutional care.

4. That controlled treatment to which I referred would include such elements as: one—medical care, particularly during the withdrawal period, which of course, as you have heard is very brief. Withdrawal is the minor part of the problem today. Two—psychiatric and psychological services to diagnose the personality fault, in order that it can be treated; and finally, three—a staff which can interpret that diagnosis and plan of treatment into action. Such staff to give you an idea, would work through such mediums as an educational program, a vocational training program, a constructive work program, wholesome recreation and the opportunity to discuss religion and develop a workable philosophy of life. That is the type of program which I see as existant in a treatment organization.

Finally, it occurred to me as Dr. Richmond was speaking, that we're not so far from the stage when we used to think that people who had a fever or who were mentally ill were possessed of devils, and we tried to punish it out of them. It's not so many years ago that that was the practice. We're in that stage with regard to correctional work. We're trying to beat the devil or the demon out of the drug addict, and it's obvious that, until we get down to diagnosing the cause of his problem—the real cause, not just the use of drugs—and treating him, we're not going to get very far. It's high time we realized that the addict is not possessed of demons; he's got to be studied, understood and treated. When we do we'll achieve success in treatment.

One thing I caution you about. In changing from the old method of treating the mentally ill, and the person with physical ailments too, we had to acquire some knowledge concerning treatment. We had to do some research. We've done a bit, and we know how to begin treatment of certain personality problems in drug addicts today. The big thing that we required was knowledge, understanding and public support for the whole idea. In this regard, if we think that the four dollars a day which we spend on drug addicts in Canadian prisons can reform them at the same time that we spend sixteen dollars a day to get a broken leg or an in-grown toe nail fixed in a general hospital, we might just as well go on trying to beat the devil out of the drug addict. We can't call it treatment unless we put the necessary resources into it. As I say, to give you a rough idea of the change in care which is required, we spend \$4.00 a day trying to fix broken personalities of drug addicts in prison, while we spend \$16.50 per day just for general hospital care to get a leg fixed.

Senator HODGES: That \$4.00 is the cost of every inmate of the penitentiary? I mean, you don't mean it's confined to drug addicts?

Mr. CHRISTIE: No, that's the rough average cost, four to five dollars.

Senator HOWDEN: Do you get away with four dollars a day in an institution?

Mr. CHRISTIE: Yes.

Senator HOWDEN: Do you. That is surprising.

Mr. CHRISTIE: The Archambault Commission figures, which are out-of-date as far as the outside cost of living index is concerned, are still pretty well the same for Canadian prisons. In prisons we get by with \$1,500 a year per prisoner, and divided by three hundred and sixty-five days it gives you your exact cost per prisoner. The treatment is much the same, except that it's a little more restrictive in Oakalla for the drug addict to keep him segregated.

Before we get into any questions, I want to deal with a few other points that came to my mind as Dr. Richmond was speaking, because the foregoing sums up my main thoughts with regard to drug addicts.

Someone spoke of institutions being self-supporting. As an administrator that interests me. I've talked with people who have run institutions that tried to support themselves for years. I believe in prisons being allowed to produce up to their cost of operation, but in reply to the question concerning self-support, very few institutions ever produce more than a quarter to a half of their cost of operation. Prison settings are wasteful when it comes to productivity, and, unless you make them slave driving organizations, they seldom, if ever, produce more than one quarter to a half of their cost. Nevertheless, it should be done, if for no other reason than to provide them with constructive work.

Senator HOWDEN: May I interrupt you there for a moment. We have a submission from Chief Mulligan, at Ottawa, with regard to this matter and he contemplates the day when prisoners, all prisoners, but particularly the violent one, will be ostracized on a prison farm where they would produce milk and cream and he thinks that such a farm ought to, perhaps, meet its costs. They would be kept there for long periods if necessary.

That idea appealed to me at the time, very greatly because there seems to be no hardship about it, no drive about it; a man would be employed, probably, at a more or less pleasurable activity—

Mr. CHRISTIE: Well, to be absolutely frank with you, most addicts would not consider it a "pleasurable" activity. Work is one of the things which—

Senator HOWDEN: I know that.

Mr. CHRISTIE: But I do believe that it is an essential part of his rehabilitation. It is tragic that people, when they start to discuss prison industries, don't realize that prison industries have been operating effectively for many years. Guelph Reformatory, Ontario, has been producing as part of its training program for over twenty-five years. Oakalla has been producing licence plates and running a hundred acre farm for twenty years. That particular part of Mr. Mulligan's presentation I would endorse heartily.

Senator HOWDEN: Such environment, do you not think, takes up much of the mind of the addict pleurably, and when he's not thinking about himself and when he's thinking about other things that require his thoughts, why, he's more or less free from the constant desire for morphine.

Mr. CHRISTIE: I agree with you. We're thinking along the same lines. There's no doubt that an extension of the useful work idea is long over-due in Canadian institutions, particularly in the West. In Ontario they have gone ahead with it, but as yet, the idea has not been fully developed here.

The CHAIRMAN: In other words, we ought to get rid of the idea that work is a curse.

Mr. CHRISTIE: We've got to get rid of the idea that work is a curse and what is more of a problem, we have to understand that men working in prison is not

out of harmony with any union principle. That is our biggest problem. Because a man is out of work on the outside he automatically feels that he is being—

Senator HOWDEN: faced with starvation.

Mr. CHRISTIE: Yes, though the prisoners' work seldom effects the economy adversely—on the contrary it eases the tax burden.

The next point that struck me was, you spoke of incurables. At one point in the discussion somebody said that some of the addicts, or a good portion of them, must be considered as incurable. I'd like to speak to that point. Addicts are curable. We know enough today to cure many addicts—not spending \$4.00 a day but that which is necessary—not wasting, but spending the resources which will most quickly and efficiently bring about their establishment as good citizens.

In prison work, because we're at an elementary stage, we don't get unhappy when we see a man come back to prison who has returned less vicious, less bitter, a petty thief instead of a gangster. We, therefore, measure our treatment the same way as a medical man who tries to fix a useless leg and gets his patient to walk but with a limp. In other words, we are happy about progress. We don't bring about a complete cure, immediately. We frequently, for example, make a drug addict into an alcoholic, which we, wrongly or rightly, assume is progress, and we hope that we will go on from that and get at the basic personality fault, which will eventually establish him as a self-supporting, personally satisfied and socially useful person.

Mr. LIEFF: In connection with what you've just said, I suppose you are making an alcoholic out of a man who had been an alcoholic before he went on drugs and not a fellow who hadn't?

Mr. CHRISTIE: That could be, but not necessarily. It is not uncommon to see a change of circumstances bring about a marked change of intensity in the neurotic, psychotic, normal, or psychopathic qualities of prisoners. We know enough today to make a start in the modification of delinquent personalities.

Senator LEGER: Would you say, sir, that in these cases there is more or less a lack of christian principles in these addicts?

Mr. CHRISTIE: I would not wish to confine my remarks to addicts in that regard, but as I commented earlier, part of the treatment which is most commonly required by the offender, including the addict, is an opportunity for religious discussion and a re-vamping of his philosophy of life to the point where it becomes a workable thing.

Finally, about this matter of incurability. Polio was incurable. Other ills have been incurable. As you know there are many conditions that were incurable a few years ago, but for us to sit here and say that a drug addict is incurable, because in some cases we can't see the light with regard to their treatment, would be utterly ridiculous. Furthermore, I think it would be a shame for any Senate Committee to say, just because something hasn't been done, that it can't be done.

Senator HODGES: Within your experience, Warden, have you known many who have been absolutely cured?

Mr. CHRISTIE: I have known addicts who have been absolutely cured, but what is more to the point, I am convinced that the addicts are the same as the other delinquents with whom we can set up our group and cure at will almost. For certain groups we know the answer conclusively. Other groups we're doubtful about. There are some, the ones we refer to as incurable, for whom we have yet to find the answer, but to say that addicts are incurable is wrong.

Senator HOWDEN: That depends on the more or less "Morally or bust".

. Mr. CHRISTIE: No, it depends upon our resources, our research and our knowledge.

Senator HOWDEN: But if a man hasn't got a wish to get well, he doesn't get well.

Mr. CHRISTIE: That was my next point. You mentioned interest in change and his wish to get well as being essential. Creating a wish to get well, or an interest in reformation, is a fundamental part of treatment. It's the biggest part of treatment. Whether he's a car thief, a petty thief, a bank robber or a drug addict, creating that interest in reform, showing him how he can be just as happy, and a lot more happy, by a different way of life is the main part of the treatment process.

Senator LEGER: You would say, then, that everybody has a liking for something and you want to find out in that patient, or addict, what his likings would be and then teach him.

Mr. CHRISTIE: Yes, that is correct. I believe that in addicts—I would go farther and say I know that in addicts—as in other offenders, there exists the qualities which are necessary, the human qualities which are necessary, given the proper care and treatment to nurture a good citizen. These qualities exist in each one of them.

Senator HOWDEN: Mr. Christie, have you cured a number of addicts in your experience?

Mr. CHRISTIE: I have seen addicts cured, but I am only the administrator. I have a staff who work independently under me with regard to their treatment work but within the scope of my administration. My job is to see that they are able to work as a team. I have seen this team successfully rehabilitate addicts.

Senator HOWDEN: You have seen a man cured?

Mr. CHRISTIE: Yes.

Senator HORNER: Under your guidance, of course, they were forced to remain cured.

Mr. CHRISTIE: I mentioned earlier that in the treatment of addiction, particularly as in the treatment of other delinquency, control is an essential factor.

Senator HORNER: I just want to comment that the lack of money—How, we have been told by several witnesses, of course delinquency comes first, and a wrong personality. Now, my contention is that all the money will have no difference whatever. You'll still have these people with you regardless of any amount of money that you are given to spend on them. The difference you quoted—four dollars a day or sixteen for a man with a broken leg. Even if you had sixteen or twenty dollars a day I don't think you will change the personality of a great many of these people. I'm sorry to say that, but I don't think it's possible.

Mr. CHRISTIE: You're entitled to your point of view, but as long as you have as many people as we have being rehabilitated where we do spend the money, I think you're going to have to acknowledge the fact.

The CHAIRMAN: Mr. Christie, what is the population of the prison and how many drug addicts have you, and could you define how you segregate them and what different treatment you give the drug addict prisoner as compared with the others.

Mr. CHRISTIE: We can't say that the drug addict is being treated today. We give him withdrawal, and humane physical care. We don't treat his underlying personality fault.

The CHAIRMAN: You segregate them?

Mr. CHRISTIE: We segregate them in order to facilitate the treatment of others. From my point of view as an administrator, it is obvious that the same money which will rehabilitate one extreme addict might rehabilitate two first offenders, and therefore, I spend my money on the first offenders.

The CHAIRMAN: How many have you at present—drug addicts?

Mr. CHRISTIE: We admit nine thousand people a year in Oakalla. We have one thousand incarcerated at any one time. Out of that thousand, roughly one hundred and fifty will be addicts.

Senator HODGES: And are they segregated from the rest of the inmates for the whole time?

Mr. CHRISTIE: They are segregated from the rest of the institution, yes.

Senator HODGES: Is there any truth in the allegations one often hears that young offenders, for instance, often learn their first lesson in drug addiction in the penitentiaries and jails?

Mr. CHRISTIE: They have in institutions which I have run, and they did in the beginning stages when I came to Oakalla. Any Warden who said that he had wiped drugs out of his institution completely—would be demonstrating his ignorance. However, I think it's quite safe to say that there are no youngsters being introduced to drug addiction in Oakalla today. Primarily because the smuggling of drugs is almost completely eliminated. It's a very rare occurrence today when drugs get into the institution. Secondly, when they do get in, they would go to the addict group who are completely segregated from the younger and more reformable inmates.

The CHAIRMAN: Are they examined periodically warden? To see if they have been using drugs illegally?

Mr. CHRISTIE: The drug addict is seen every day by the people who work with him, and periodically by the doctor, but you wouldn't need to have an examination for this specific purpose.

Senator McKEEN: Of this one hundred and fifty that you have in there of your thousand at any one time, is it one hundred and fifty on charges of drug addiction or drug offenses, or are they criminals that are addicted to drugs but are in there for other offenses as well as it might be on a drug addiction charge?

Mr. CHRISTIE: It's both. We segregate drug addicts on the basis of whether they're drug addicts, not on the basis of their charge, because their charge, as you suggested, frequently has nothing to do with drugs.

Senator McKEEN: Well, the one hundred and fifty then would be the total that were in there for one reason or another and that were drug addicts, fifteen per cent?

Mr. CHRISTIE: That is correct. We know most of these people from a while back, and many of our staff are very good at picking out the addicts. Of course there are other ways of finding out. The first indication is usually that the drug addict coming in requests withdrawal treatment.

Senator TURGEON: Do you find many persons in prison for causes not related whatever to drugs and without knowledge of their having drug habits. Do you find many of them who are drug addicts, but find it out only after they are in the penitentiary.

Mr. CHRISTIE: I miss the point of your question, sir.

Senator TURGEON: Do you find, of the total number in prison, any prisoners of whom there was no knowledge previous to their imprisonment of addiction, who are drug addicts? Without the authorities having any knowledge of it before? He was in prison for some other offense.

Mr. CHRISTIE: Do we find many drug addicts who—

Senator TURGEON: —are in prison for offenses not related to drugs—

Mr. CHRISTIE: Quite a number.

Senator TURGEON: —and who are unknown to be drug addicts but prove to be so after they're in Oakalla.

Mr. CHRISTIE: No. We don't miss very many. Actually, it's very easy to pick them out.

Mr. LIEFF: Your folks are all serving sentences, are they not? They're not on remand?

Mr. CHRISTIE: We have approximately one hundred and sixty awaiting trial—waiting appeal and on remand—at any one time.

Mr. LIEFF: Are they on remand in the first instance, do you mean?

Mr. CHRISTIE: Oakalla handles all people who eventually go to the penitentiary. Oakalla Prison Farm is the institution in South Burnaby—it's not the penitentiary, which is in New Westminster.

Mr. LIEFF: Oh, I see, it's the local institution.

Mr. CHRISTIE: Oakalla is the local institution.

Senator GERSHAW: Mr. Chairman, the witness spoke of spending \$4.00 a day and indicated that if more money was spent more of these addicts would be cured. What additional facilities would be required to get an increase in the number of cures.

Mr. CHRISTIE: I would like to say first of all that additional money doesn't always mean that you get additional results. It must be spent wisely. The things which would be required are, one, a constructive work program for every man. A man has to work to maintain his self-respect and to learn how to keep himself after release.

The CHAIRMAN: Do you find much difficulty in getting them to work.

Mr. CHRISTIE: It's quite a job to get them to work to begin with, but after a while they swing into it and they're happier in the long run and more comfortable and healthy. They build up their weight and that sort of thing faster on a work program than they do sitting around. But it's frequently a difficult task getting them started.

Number two, many of them require some education to earn their living in society today. Some of them are illiterate. Many require mathematics or other types of education. Today, the only way our group can get an education is by correspondence courses, although we do have a small group of Burnaby school teachers who volunteer their time. The inmates study in the evening after a full day's work. They can take a correspondence course, if they have the money to pay for it, and the school teacher will help them over the rough spots. Free courses can frequently be arranged for inmates without funds.

The CHAIRMAN: Do you find it very popular?

Mr. CHRISTIE: It's not popular. It's difficult. There are quite a number who try the courses, but without help there are very few who complete them. The man who needs an education is often the man who isn't able to handle it on his own. He needs a teacher.

Senator HODGES: There is nothing done through the correspondence courses put out by the Provincial Education Department?

Mr. CHRISTIE: Those are the correspondence courses we use.

Senator HODGES: Oh, you use those.

Mr. CHRISTIE: Yes. But a man who needs education by the time he gets to prison, is usually the man who needs help with such a course.

Senator HODGES: Yes, quite.

Mr. CHRISTIE: We do it for the women, we can't for the men.

Senator McKEEN: You spoke of making licence plates and other things in there. Is there any pay goes to any of these prisoners so that they could get the money to buy these courses?

Mr. CHRISTIE: Ten cents a day, but they can't get it until they get out.

Senator McKEEN: Oh, I see. If they were earning something they could pay for these courses and during the time out there if there was a credit against it, that might assist them somewhat.

Mr. CHRISTIE: It's the practice in some prisons to establish an account for a man which he can draw on for useful purchases such as correspondence courses and that sort of thing.

Vocational training. (If I take too much of your time just cut me off.) Today, you can't take an addict out to an employer and ask him to employ the man. You'd do it and you'd get by with it in a few cases, but it would be unfair to ask the employer who is good enough to be interested, not only to take a man in who is a poor risk, but also to expect him to take a man in who has no training and whom he must go ahead and train as well. It's just asking too much. Therefore, you have to train a man if you want a machine operator, a carpenter or that sort of thing. You can expect an employer to be philanthropic and employ a poor risk, if he's got the training, and if, for the three weeks that he stays with him, he at least does some portion of three weeks' work. But if he's just going to train a man for three weeks and have a complete loss, and probably have his till rifled at the same time, it's not a fair proposition. In other words, vocational training is little enough to do for these people and the people who will try to employ them. They've got to be able to go into a job and hold it. We're training them as ditch diggers today, but there aren't very many jobs for ditch diggers, though a lot of them do go out to laboring jobs.

But it's pretty hard—they're a drug on the market and, as you know, with their poor background it's hard to find jobs for them. You've got to give them vocational training and wholesome recreation—you've got to supplement your hard work program. In a large percentage of cases, their main interests centre around a deck of cards. You've got to teach them how to play volley-ball, how to play soft-ball—something we're doing today as much as we can—teach them to get out, take part in a few sports, track-meets and that sort of things. They get into it enthusiastically, and you get a completely different atmosphere and attitude towards life. They get more out of a sports day, when they compete in a tug-o-war and that sort of thing, than they do when they're sitting around, even if they play bridge. We don't allow gambling, but it's pretty hard to know what's going on as the cards are flying.

Senator HOWDEN: The same things applies to an ordinary drunkard but very much more so to an addict.

Mr. CHRISTIE: Yes, that's right. It's a difference in degree.

You have work, education, vocational training, wholesome recreation, and finally, possibly the most important, an opportunity to participate in what we call a socialization program, in which we teach people to live with people—group work, socialization—call it what you will. A portion of that program involves sitting down and teaching them how to eat at a table and how to share their food. We pass our serving dishes around the table at our Young Offenders' Unit and Westgate institutions. We aren't able to do it with the addicts. They just pick up their meals cafeteria style and sit in their cells, with the toilet on one side and the bed on the other. But, in the Westgate unit, where we've been able to get it started, we sit them around a table. The first time a man sits down he may hog more than his share, and by the time it gets around to the other side of the table they run short. The second time you

pass the dish around the other way, and he ends up short. The third time he takes his share. He has learned something about living with people. Possibly most important, are the group discussions. If you have the right staff, you work into a discussion on such subjects as religion, and out of the discussion you get some for it and some against it. A chap discusses his philosophy of life, and out of that discussion if he decides he isn't going to go to church, he at least knows why. Eventually, as you know, the logic asserts itself, and men acquire a philosophy of life, whether it's AA, whether it's Presbyterian, or whether it's some other approach—a philosophy of life which is workable in our society.

Those are the main elements.

Senator GERSHAW: The cost of the staff and the people who can carry those things out.

Mr. CHRISTIE: I was just going to finish off by saying all these things can be done only by training staff, as Dr. Richmond has mentioned. I never used to talk "money" at all, but the fact remains that I have had a very difficult job in attempting to recruit staff to do these things, and you can't do it, as I've said previously, for \$225 per month.

Senator HODGES: It is a case of educating the public to realize that it is far cheaper to spend money in the way you suggest than to spend money in having these people come back again and again and be a burden.

Mr. CHRISTIE: That's right.

Senator BEAUBIEN: If you paid higher wages you would be able to get the staff?

Mr. CHRISTIE: That's right. I think we can pay less than the going wage for that type of service, because you tend to recruit a missionary type of individual, but a missionary type of individual still has to feed his family and his children.

Senator STAMBAUGH: That is what I was going to say. You pretty nearly need dedicated people for that kind of work.

Mr. CHRISTIE: Dedicated people or people who can become dedicated. I don't want "dedicated" to sound too starchy, but you must have people who are willing to give of themselves to do the job. It's an essential feature. It has taken a lot of years to fix it with such crystal clearness in my mind, but it takes a certain type of person to rehabilitate people.

Senator HORNER: Of course, they have a large penitentiary farm in Saskatchewan. They have had for thirty to forty years and they work crews and they work the men and they have training the same as our mental institutions in Saskatchewan. They have huge farms and they have to work and that sort of thing they have there.

Mr. CHRISTIE: I ran the prisons of Saskatchewan for six years, during which time they closed the Mooseman jail completely. Certainly the Saskatchewan method has a lot to commend it.

Senator BEAUBIEN: Did I understand you to say that if you paid the wages—reasonable wages—under the present conditions, you would be able to get qualified people to undertake the work which you have outlined in your brief?

Mr. CHRISTIE: That is right.

Senator BEAUBIEN: These people are available?

Mr. CHRISTIE: My point is two fold. One, as Dr. Richmond said, there are people available if it were made possible for them to come to us. These people require the wages and the opportunity to do a job. Secondly, we would have to train many people. When we cannot recruit the trained product, we must recruit a man who has the qualities of personality which make it possible for

him to be trained. Furthermore, he must have a certain amount of academic background to be able to understand what is being talked about. We have to recruit the man with that potential, and be able to pay him enough money so that after we have trained him he doesn't leave, as they do now, to somebody else who can pay the price.

The CHAIRMAN: May I ask, Mr. Christie, if you get any instructions from the Provincial Department of Health or the Provincial Government, giving you direction as to endeavouring to cure the addicts or are you just merely put in charge of the prisoner and have to use your own judgment in the matter? You are speaking about staff and I was thinking, suppose the staff were given to you, is there a principle laid down by the Provincial Government that you can go ahead and endeavour to cure them.

Mr. CHRISTIE: No—but there is a team which does some treatment in Oakalla—it is referred to as the treatment team—it starts with classification and works on from there. However, they are very limited in number, and, although they receive a great deal of help from the Health Department, we're at such an elementary stage in our development that the help at this point has been related just to getting the kitchen tidied up and the place sanitary. We haven't got to the point that the Health Department would feel they have a right to move into the area of treatment. Prisons haven't been given the resources or the authority necessary to make treatment possible.

The CHAIRMAN: What I'm trying to get at, for the past number of years the Provincial authorities, not only here but elsewhere, have just taken the prisoners from the courts and put them in jail and the warden has looked after the prisoners and he has segregated the drug addicts from the criminals. But his duty has been, up until now at least, just to keep him confined and keep him useful if at all possible. Now I am wondering if any direction would have to be given, if the Provincial authorities would have to take hold of this and go into it and say we're going to try to cure these drug addicts and go on a new system. You couldn't just take a staff in unless you got some direction from the Provincial Authorities. Maybe I'm wrong, Mr. Christie. I'm just trying to get the picture clear in my own mind.

Mr. CHRISTIE: I think you're right. We would have to have the assistance of all related departments—the education department from the educational group:—the health department to cover the health aspects: and the mental health services for the psychiatric. We've have to have the assistance of those departments in doing the job; which particular department ends up responsible for the total job is not as important as the fact, first of all, that you obtain staff who are able to do the job—the staff and resources—and that the interested departments co-operate to see that the job is done.

The people who have studied this field fairly intimately across Canada, seem to agree that progress in this field, since you mention the Health Department, would be a move similar to that which happened in Health Departments in which Federal Health grants were established for provinces which were prepared to measure up to certain standards of performance. The feeling in Canada is that until Federal correctional grants either through the Health Department or some other Department, are established it will be impossible for the Provincial Governments to set up the necessary resources to do the job. Federal correctional grants—

Senator LEGER: Federal and Provincial grants.

Mr. CHRISTIE: The way it's done is this. Federal money is made available to a Province which is willing to measure up to certain standards.

The CHAIRMAN: I'm glad I mentioned it because it brought out the thought I had in mind.

Senator HORNER: Just one question. What would you think—would it help the situation here if those narcotics were taken, we'll say, to a Federal institution in other parts of Canada, so that when they were released they wouldn't be among their old friends again. What would you think of that? For instance, taken to some Federal institution and there taught work and there let go to work and prevent them coming back in with the larger group here in Vancouver.

Mr. CHRISTIE: I don't think its important who does it, and I don't think where it's done is quite as important as some people believe, as long as it's done in a proper way. You can have control on the outskirts of Vancouver or on an island. Experience has shown, however, that on an island you can't get the staff.

Senator HORNER: You can't prevent them grouping together here though after being released after serving their time or their cure.

Mr. CHRISTIE: I think the after-care authorities would have to consider each individual case. I think you'd find some cases whose family were here, as well as other people who could support them and help them. It would be important that in some cases they stay right here for their rehabilitation, whereas, in other cases, it would be most appropriate to place them at a distance. I think it would have to be an individual decision for each person, and would be dependent on the after-care resources available, without which an institution's work is often wasted. You can retrain a man, but if you just dump him loose without any after-care you're often wasting your money.

Senator McKEEN: Mr. Christie, do you happen to know—it isn't in your jurisdiction, I know—but is there any money available for work on addicts in the Federal penitentiary in New Westminster?

Mr. CHRISTIE: I think Warden Douglass is appearing before you and it might be more appropriate if I left that for him to answer.

The CHAIRMAN: Any other questions, honourable Senators? If not, Mr. Christie, may I express the appreciation of the Committee for your appearing here.

Mr. CHRISTIE: Thank you.

The CHAIRMAN: Honourable Senators, we have two witnesses left to appear before noon; Mr. E. E. Winch and Mrs. E. MacCullie. I don't see Mrs. MacCullie so Mr. Winch would you come forward please?

Mrs. MacCullie has given considerable time to not only the aged people but also to drug addicts, and her name was suggested by Mayor Hume.

Mr. Winch, I welcome you on behalf of our Committee.

Senator HODGES: Mr. Chairman, I think the Senators should know that Mr. Winch is a member of the Provincial Legislature and has been for twenty-two years.

The CHAIRMAN: MLA—I took it that all Canadian Senators would know what "MLA" meant.

Senator HODGES: Well, I think they should know that he's been a member of the Legislature for twenty-two years and a very wonderful career.

The CHAIRMAN: He has certainly had a long career and an old one. I don't know how many elections he has won but he has been here the longest.

Senator McKEEN: He sat under the last speaker as Speaker of the House.

Senator HODGES: As a matter of fact we sat in the House together for twelve years. We didn't always agree, but that made it all the more interesting.

Senator TURGEON: I hope you'll all agree on this.

Mr. WINCH: Mr. Chairman, I think that Mrs. Hodges could write my speech for me, she's heard me so often.

Mr. Chairman, ladies and gentlemen. I greatly appreciate the opportunity of appearing before this important and history making Committee, to present some views on the problem of drug addiction.

May I preface it by explaining that my original interest was due to a son of one of my old friends becoming an addict due to his association with others while serving a three months sentence in Oakalla for having taken a car for a joy ride without permission of the owner. Whilst he undoubtedly committed an offence against society, the latter committed a crime against him, and against itself, for he went into jail one of the cleanest and finest youths I have ever known. He came out a ruined person and apparently a permanent social liability.

The CHAIRMAN: What year was that?

Mr. WINCH: That goes back about twenty years.

Senator TURGEON: Thirty years?

Mr. WINCH: Twenty years. He has since been in the penitentiary for robbing a drug store. His wife became an addict and is now a patient in a mental hospital. This experience caused me to look into the subject in its wider social aspects and I found it was a major problem of increasing proportions.

Following investigations I came to the conclusion that the public approach and official policy of treating addiction solely on a criminal basis was fundamentally wrong; consequently, for many years, I have endeavored to bring to the attention of the Provincial Legislature and the public generally, views, policies, treatments, and conditions existing in other lands and other places where conditions are much more satisfactory than in Canada.

Later, in 1947, I communicated with 900 doctors in B.C., furnishing them with official data covering an analysis of drug addicts committed to Oakalla jail over a ten-year period. Two questions were submitted to the above doctors for their approval or disapproval.

1. The establishment of a hospital for the treatment of drug addicts with a view of their rehabilitation—

2. The establishment of legalized medical clinics for the treatment of certified chronic drug addicts for the purpose of administering the minimum amount which will enable them to carry on their means of livelihood and refrain from having to resort to underworld sources of drug supply. (A "certified" drug addict is one who had been treated at the aforementioned hospital without a cure being affected.)

Four hundred doctors replied. 352 approved of the first project and 21 disapproved. 255 approved of the second and seventy disapproved.

Many of them added additional comments. Among others, the Victoria Medical Society approved both proposals. Among the comments submitted by the individual doctors were such as:

Oh, very much worth while. Much needed. Long overdue—it's a must. Cannot think of anything more urgently needed. The best suggestion yet made to deal with the problem. The most rational approach that has yet been made. This is the first constructive step in the right direction. With a practice of over 4,000 patients, I suggest immediate action along those lines. A prison term never cured any addict and is only an admission on the part of society and the medical profession of their ability to cope with an urgent problem. Legalized medical clinics present the only rational approach which has ever come to my knowledge. Let the illegal purveyors compete with such a clinic. The loss of their exorbitant profits will settle the matter at

once. Both proposals approved. Some such institution is urgently needed for the good of the addict as well as for the good of the medical profession.

To acquire a better understanding and assessment of our own situation and policy, a number of countries were written to with a request for information as to the magnitude of their problem and their policy in regard to treatment, and results. Their replies further confirmed my opinion that our official policy of treating narcotic addiction exclusively on a criminal basis was unrealistic, antiquated and wrong. Last year I again wrote these countries and asked to be brought up-to-date regarding their local situation.

Replies were received from Norway, Sweden, Denmark, New Zealand, New South Wales, Queensland, South Australia and other places. Brief summaries of their replies are being filed, in addition to which the "Summary of Annual Reports of Governments 1952, issued in 1953 by the United Nations Commission on Narcotic Drugs Economic and Social Council" contains the official reports of contributing countries from which I have extracted, and submit, some basic data. I will refer specifically only to Ireland, the United Kingdom and Canada. Before doing so may I ask the indulgence of the Committee to further explain my position in relation to drug addiction. I, as a layman, have to depend for my information from recognized, authoritative world-wide sources. My files on drug addiction, accumulated over the years, are the most extensive I have on any subject coming within the range of my duties as a member of the Provincial Legislature. As it is not possible to produce here my authorities in person, I have to do so through the medium of their letters and publications. I trust the Committee will not feel it an imposition for me to make a number—and occasionally somewhat extensive—of quotations from such sources—rather than advance their views as having been by myself and endorsed by them, and indulged by them.

The three to which I propose to refer: one is Ireland, which I thought might be appreciated, where the officials reported there is no evidence of addiction although one case was discovered in which morphine was obtained under false pretenses.

The United Kingdom, and I quote from their official report: "The number of addicts receiving drugs from medical sources during the year was 297. There is no evidence to suggest that addicts to manufactured drugs regularly obtain their supplies from illicit sources although, as in previous years, several addicts were known to have supplemented legitimate supplies by unlawful means (for example, forged prescriptions and concurrent supplies from more than one doctor). These are included in the foregoing estimate."

The CHAIRMAN: Excuse me for interrupting you. Have you the information as to what drug?

Mr. WINCH: No, they don't specify the type of drug.

"The majority of persons addicted to manufactured drugs are over 30 years of age. Of the 75 addicts in the professional class, 72 are doctors, 2 are dentists, and 1 is a pharmacist.

There is no compulsory treatment of addicts in the United Kingdom, and there are no state institutions specializing in the problems of addiction. There are, however, a number of public hospitals where treatment can be obtained; and some private nursing homes offer special treatment to drug addicts. As has been shown in past years, drug addiction does not present a serious problem in the United Kingdom."

Then we have an official report of Canada, and I quote. "It was estimated that there were approximately 5,000 addicts of whom roughly 7 per cent are males. Furthermore, it was reasonable to assume that addiction may be slightly on the increase—

Senator HODGES: Did you say 7 per cent.

Mr. WINCH: Seventy per cent.

Senator HODGES: Oh, I thought you said 7 per cent, I beg your pardon.

Mr. WINCH: No, seventy per cent. As bad as the women are they're not that bad.

Senator HODGES: I must say, I have to stand up for my sex sometimes.

Mr. WINCH: "—in view of the large supplies of heroin entering the country illicitly as evidenced by seizures of this drug and the steady prices maintained in the illicit traffic. Addicts should be classified in the following groups:

- (a) Medical Addicts who acquired an addiction factor super-imposed on a genuine medical condition;
- (b) Professional Personnel with psychosomatic or neurotic tendencies who have become addicted as a result of their related occupation;
- (c) Individuals with psychic problems who have drifted into sustained addiction and who constitute a major portion of the estimated number of addicts.

No definite programme of treatment has been formulated."

With reference to the concluding sentence, Canada has recently provided for more severe penalties for infringement of the Narcotic Drug Act, and there are reported to be persons who, apparently seriously, advocate capital punishment for certain offences under the Act, or life time imprisonment for second offenders. On the other hand, it is interesting, and informative, to note the policy in Great Britain where, according to the 1954 report of 179 prosecutions, 99 were fined; 47 of them fined under five pounds and 3 only, more than a hundred pounds; 48 were sent to prison for one month or less, and 2 for two years.

It is important to note the different approach of Canada and Great Britain towards punishment for the offences under the Act.

Senator McKEEN: Might I interrupt just for a minute here to ask, were those offences purely drug offences or were they criminal offences of drug addicts?

Mr. WINCH: Offences under the drug Act, oh, yes.

Unfortunately, the Opium and Narcotic Drug Act is exclusively a control measure and does not concern itself with any aspect of the treatment problem, nor is there any related Federal legislation.

Dr. Thomas Parran, at one time Surgeon General, U.S.A., so aptly said in the pamphlet "The Problem of Drug Addiction",—"The law, in effect, made criminals out of persons who were guilty only of suffering from the effects of a weakness that they could not control. If the Government insists, as it should, upon suppressing the non-medical use of narcotics, it should also provide for the medical treatment of those unfortunates who are caught in the web of suppressive measures.

Restraint should be tempered by the helpful atmosphere of medical and psychiatric treatment as far removed from prison influences as it is possible to remove it, and yet still retain control of the patient. The addict, in short, is a sick person who has no place to go; hence the necessity for Government hospitals where voluntary patients as well as prisoners can be treated. It is not expected that all addicts will be cured in the institutions, some are too defective for that. Their addiction is only a symptom of an underlying mental defect."

We know that drug addiction itself is not a criminal offence which latter is defined as the illegal possession of narcotic drugs, but in the desire for conviction of the offender (and not for their treatment as a person in need

of medical or psychiatric measures) microscopic traces of drugs have been accepted as evidence on which to base conviction. Yet, over the years, conviction, fine, and imprisonment have given no evidence of suppressing, or even controlling drug addiction, and there is no evidence to warrant assumption that increased penalties will do so for, according to Albert Deutsch, in his Public Affairs Committee pamphlet, issued in cooperation with the New York State Department of Health, he says, "dope rings are smashed time and again but new ones keep springing up because of the lure of enormous profits in the drug racket."

This receives confirmation, I note, on page 49, of this Committee's proceedings. Commissioner Nicholson of the RCMP is recorded as saying, "profits are so attractive that the gaps caused by arrests are quickly filled by other criminals and the traffic continued". This point of view must be kept in mind by those who think that by imprisonment you can prevent the illicit drug traffic.

In my opinion, although drug addiction as such, is not a crime, there is too great a tendency on the part of the general public and the law enforcement authorities to see addiction, and its victims, exclusively as belonging to the criminal element in society, and also almost exclusively as being from the ranks of non-professional workers, this latter despite the fact that authorities estimate that addiction is proportionately eight times as prevalent among the professions as among other social strata.

In Addendum "A", filed by the Honourable Paul Martin, Minister of National Health and Welfare, 848, that is, 26.4%, of the total addict population are members of medical and professional categories. It is interesting to note that in Addendum "C" there are no medical members and only 13 from professional groups shown as members of the total criminal adult population.

It rather, to my mind, indicates that there is less action taken against the addicts coming within those two categories than among the others. It may be, of course, the difficulty of proving their addiction.

Senator McKEEN: I think, Mr. Chairman, we might point—that point that came out with Mr. Winch there, the offence was the illegal possession of the drug and these professional men were not in illegal possession of it, they were legally in possession of it even though they were addicts, and the question was brought up that there should be some change in the law to cover it. I think that covers the point there. It isn't a case of less police action against them but there is no grounds for it.

Mr. WINCH: I know, the difficulty of proving it.

Senator McKEEN: Well, it isn't a case of proving because the addiction isn't a crime, it's the illegal possession.

Mr. WINCH: I think it's one of those, shall we say, legal technicalities.

It is interesting to note the difference between the number of drug addicts in jail and the number of those who are convicted as drug addicts. In a submission made by Commissioner Nicholson—and I have compared it year by year with the report of our own provincial jail, it is interesting to note the wide discrepancy. In 1944, according to Commissioner Nicholson, there were 151 convictions under the Narcotics Drug Act, but in that same year there were 237 drug addicts in our B.C. jail. Or jumping for ten years, in 1954, according to Commissioner Nicholson, there were 391 convictions under the Act, but the same year there were 537 drug addicts in our provincial jails here alone. So the number of convictions under the Act does not indicate any where near the extent of drug addiction.

The CHAIRMAN: Of course, a person could be in jail and not convicted.

Mr. WINCH: Oh, yes.

Senator HODGES: He may be waiting trial.

Senator HORNER: He could be waiting trial.

Mr. WINCH: No, no, no. Pardon me. A person awaiting trial is not on record as a prisoner in the jail.

Senator HODGES: Oh, I see.

Mr. WINCH: I notice that Dr. Stevenson said that in '53 there were 265 drug addicts in Oakalla and 192 in '54, whereas, the general report itself says there were 462 and 537, so I assume that he must have been referring to those who were convicted under the Act. He certainly could not be quoting the actual number because his statement conflicts with the number in the official report, the Annual Report of the jail itself.

The CHAIRMAN: What have you to say to that, Doctor Stambaugh?

Senator STAMBAUGH: You are giving the number that are in the jail—is Dr. Stevenson here?

The CHAIRMAN: Yes. What is the answer to that?

Dr. STEVENSON: The answer is, Mr. Chairman, that the figures Mr. Winch has given are people who are convicted under the Opium and Narcotic Drugs Act, but there are a lot of addicts convicted of other offences—vagrancy, breaking and entering, prostitution, forgery—there are, out of one hundred addicts, only forty convicted under the Opium and Narcotic Drugs Act, and sixty are convicted of other offences. That's the explanation.

Mr. WINCH: What I'm trying to get at, Mr. Chairman, is that the prevalence of drug addiction is much greater than that shown by the number of those who are convicted, under the Act.

Senator McKEEN: That has been brought out.

Mr. WINCH: Now, on the other hand, Albert Deutsch, to whom I previously referred says, and I quote; "No economic or social class is immune to addiction. The addicts who pass through our hospitals and prisons come from every conceivable occupation. Many wealthy addicts escape detection throughout life because they can pay others to take the risk of getting drugs for them.

Most professionals (especially physicians, nurses and dentists) can hide their addiction indefinitely because of relatively easy access to the supply.

Another false belief is that nearly all addicts are criminals before they start using drugs. The facts indicate that many, probably at least half, of our addicts have no criminal record prior to their addiction." I recognize that there is definitely a conflict of opinion there, but that is due, in my opinion, to those who quote the majority as being criminals before addiction are dealing only with those who come within their purview as criminals. But drug addiction includes many outside of the category who do not come to the attention of the authorities.

Senator HOWDEN: In other words, there are many addicts who don't get into jail at all.

Mr. WINCH: Oh, many, very many, yes.

Now, Josie, in the report on Drug Addiction in Canada which was published by authority of the Honourable Paul Martin, states that, "86 per cent of those convicted under the Narcotic Act are shown as temperate, and 7 per cent intemperate. Addiction to opiates is not conducive to violent crime, and experience in Canada, as elsewhere, is that law-breaking by addicts consists mainly of infractions of the narcotic laws. Theft is the next most important type of offence, but addicts are rarely guilty of crimes of violence."

Before consigning all addicts into the criminal-addict class (those who are criminals before they became addicts) we should give serious attention to the addict-criminal class—those who were addicts before they became criminals—which necessitates the consideration of reasons why persons become addicts.

Many international authorities admit that no one is immune from the possibility of addiction.

Canada's own report to the United Nations mentions three classifications:

1. Medical addicts,
2. Professional personnel,
3. Individuals with psychic problems.

Josie, in the report that I have just referred to states, "Studies have shown that a considerable proportion of addiction results from the medical use of narcotics. Addiction may develop in three weeks of narcotic administration."

He also lists his causes: opportunity, injudicious use of drugs in medical treatment, self-treatment for various conditions, contagion, curiosity, self-indulgence, search for new experiences or, possibly, even as an aid to a life of crime."

Wolff, in his publication on "The Treatment of Drug Addicts" (that was issued under the aegis of the League of Nations, the World Health Organization) he says—

Senator HORNER: What position does he occupy, that man you are quoting just now?

Mr. WINCH: His is a publication issued under the authority of the—

Unidentified: Narcotics Commission?

Mr. WINCH: Yes, "The Treatment of Drug Addicts" is a critical survey published under the aegis of the World Health Organization, so he is an international authority.

He says, "Before an addict is treated, answers should be obtained to two questions. What was the original aim in taking the drug and how did addiction actually begin—actively, with the consent of the will, or passively, from gradual seduction by the drug. The purpose being to find out if the cause of the addiction is physical or mental."

That, Mr. Chairman, I was particularly interested this morning to hear Warden Christie who emphasized the same point.

The question so frequently asked, "does an addict wish to be cured" is possibly best answered by the experience of Lexington Hospital and the number of volunteer inmates which, according to a letter which I received from Dr. Vogel, Medical Officer-in-Charge, under date of December 21, 1950, "for the first time in the history of the hospital, voluntary patients out-numbered term patients."

And again, under the date of March 6, 1952, Dr. Chapman, who is the Medical Director of the same institution, wrote, "74 per cent of the admissions were voluntary ones."

The inevitable question, as often asked, is "can drug addiction be cured", and supposedly authoritative statements have been made that "no drug addict is ever cured" on the assumption that there is always the possibility of a relapse.

Well, if we assume that, as a basis of justification, saying "no addict is ever cured", and, as authorities state, "no one is immune from the possibility of drug addiction", then we are all potential drug addicts.

Senator HOWDEN: Hear, hear.

Mr. WINCH: Admittedly many relapses do occur but according to Wolff, whom I previously quoted, "It is very important to stress that the study of Dr. Pescor does not support the general belief that a drug addict can never be cured. From the general point of view, the outlook is good for a man with normal personality and some moral, mental and physical strength, for whom an opportunity to work can be secured in a healthy environment, but for all other types it is guarded and depends upon the extent to which personality exists as a background.

There are two main points to be considered in compulsory treatment:

- (1) To compel an addict to take and complete the treatment—and also,
- (2) To detain an addict who has begun the cure until he has completed it.

These would require legislation to implement, which, of course, this Committee recognizes.

Drug addicts or chronic alcoholics are not primarily criminals but are unable to control themselves.

How long a drug addict should remain in an institution if he is to derive the maximum benefit from his treatment continues to be one of the most controversial matters. For obvious reasons, particularly because they do not understand their morbid state, many addicts want to leave the hospital as early as possible. This is undoubtedly contrary to their own interests and to their chances of being cured. But the other extreme is also erroneous, that the only cured addict is the dead addict and who advocate permanent segregation or long-term imprisonment, not for its therapeutic value but as a deterrent to others who might be tempted to use drugs."

A report I received, issued by the Lexington Hospital in 1946 stated that "a five-year follow-up survey of former addict patients showed 15 per cent were reported abstinent; 26 per cent using narcotics; 53 per cent status unknown, but most of those in the 'unknown' category can well be considered to have attained social recovery as most of them are discharged prisoner or probationary patients whose finger prints are on record and no infraction of any laws have been received at the hospital where such reports would have been made if any subsequent violations occurred."

Therefore, they assume, on those grounds, that they have not reverted.

Senator HOWDEN: Mr. Winch, your remarks are not peculiar in that respect because I think this Committee recognizes the fact that any individual who is guilty of a subversive social threat, if you like, or habit, is always liable to return to it, no matter what it is, whether it's prostitution or any other form of non-social propriety.

Mr. WINCH: Oh, yes.

Senator HOWDEN: There's nothing special about that.

Mr. WINCH: No. From the newspaper report, I notice that Magistrate Orr was before the Committee yesterday, and I wonder if he reported, as he did to the Vancouver Community Chest Special Committee on Narcotic Addiction, his visit to Lexington Hospital. He reported to the Committee that the hospital estimate was 25 per cent of the inmates cured.

The CHAIRMAN: He didn't deal with Lexington so far as I know.

Mr. WINCH: He made a special visit to Lexington for the purpose of getting first-hand information.

Senator McKEEN: He said we would get that from Dr. Stevenson who made a fuller report.

Mr. WINCH: Oh. At any rate—

The CHAIRMAN: We are making special efforts to get the head of the institutions to come to Ottawa to tell us about that.

Mr. WINCH: Yes. I'm very delighted to hear that you are doing so.

The Annual Reports of the Government of Great Britain and Northern Ireland to the United Nations, for three successive years stated that during the respective years, 11 men and 10 women; 18 men and 6 women; and 12 men and 9 women, were reported as having been cured of their addiction.

Now, I'm emphasizing that, Mr. Chairman, because of the mistaken view held by so many that a drug addict cannot be cured. And I am delighted to hear the very definite stand taken by Warden Christie in that regard.

Ex-Superintendent Wilson, of the R.C.M.P. in an article to the *Daily Province*, August 16, 1952, said, "In actual point of fact, a drug addict can be cured. However, due to the present lack of adequate provision in this country for the treatment of drug addiction, there is only one class of addict for whom there is any hope of a permanent cure. These are the relatively few professional and business men who have families and business and social responsibilities. Such individuals, upon their release from a mental hospital or private sanitarium, return to their daily work and surroundings freed from the contaminating influence of contact with other addicts. They usually are of superior mental attainments and have a definite incentive—their home, families, and business—to fight against any reversion to the habit."

Because of that, Mr. Chairman, I feel the point emphasized again by Mr. Christie this morning, is that the environment to which I refer, is going to have such an important bearing on whether they actually recover from their addiction or whether they revert. If society rejects them, then that section of society which they had been previously associating with, will accept them and they will revert. An effort must be made to enable them to revert to an environment which will be beneficial to them.

Now, Josie, according to the Annual Report of the Department of Health, 1924, says, "Time is a major factor in treatment and on an average six to nine months are required. The environment to which an addict returns is an important factor in determining whether or not he will relapse and if he can be provided with work in an environment that affords a minimum of irritation and temptation, the prognosis is good. However, as with the chronic alcoholics, many relapses may eventually be followed by permanent cure."

According to newspaper reports, a number of persons—mainly without actual experience in the remedial treatment of drug addiction—have advocated permanent segregation of addicts after two convictions, using as an argument the assertion that "no addict is ever cured." Against these points-of-view I have a report received from the Medical Director of Lexington Hospital for the treatment of drug addiction showing 12,000 first admissions, 6,555 from two to ten admissions, 115 from eleven to twenty admissions, and 4 from twenty-one to twenty-six times.

Obviously, with their long experience they do not regard any case as hopeless.

Under date of January 27th of this year, the Medical Officer-in-Charge writes, "The word 'cured' has been defined in a number of different ways. I can give you some information based on experience at this hospital which may be useful. There are three types of narcotic addicts admitted to the hospital; prisoners from the Federal Courts, probationers from the Federal Courts, and voluntary patients. Both the prisoners and the probationers are required by the Court to remain for periods of time sufficiently long so that they can be discharged as having recovered from addiction. Prisoners stay from one to five or even more years."

As you are proposing to have one of the officers from Lexington, I will skip the balance of the material I have from Lexington as you will get it first-hand from him.

Now to summarize, Mr. Chairman, I consider the present Canadian policy in relation to drug addiction to be archaic, unrealistic and ineffective.

Archaic because it has remained stationary over many years and has failed to profit by the experience of other countries.

Unrealistic because it fails to take into consideration the various factors which lead individuals into addiction and, consequently, treats the medically

and accidentally-addicted in the same way as the mentally weak, irresponsible, or socially antagonistic and on the apparent assumption that increasing penalties would be an effective deterrent.

Ineffective as evidenced by the official report to the United Nations Commission on Narcotic Drugs by our jail reports.

I am of the opinion that imprisonment does not prevent, nor does it cure, drug addiction, but has undoubtedly made many by association of non-addicts with addicts and in support of the latter statement I quote from the B.C. Jail Report of 1953 (the latest available)—

"At the time of the riot an attempt had been made to segregate the drug addicts in order that their drug traffic could be isolated.

These restrictions of freedom, particularly to the addict, who previously had been able to obtain and distribute drugs weekly, coupled with the elimination of the hundred or more trusty positions, represented a loss of inmate control, and a more restricted life."

And I would again like to draw your attention, Mr. Chairman, even in Oakalla drugs were freely available, in fact it has been said that drugs were more readily obtainable in the jail than they were outside.

Senator HODGES: That is not the report I have been told here.

Mr. WINCH: I'm quoting from the official report. I learned over in Victoria—

The CHAIRMAN: What date is that?

Mr. WINCH: 1953 report.

Senator HORNER: Mr. Christie admitted—

Senator McKEEN: Before, but he said not now.

Mr. WINCH: Not now, oh, no. But what I want to point out to you and to confirm my opening statement, that the youth who became contaminated in jail because of lack of segregation. Over the years that condition has prevailed and people who went in non-addicts became addicts by association in the jail. We blame them instead of blaming society that was responsible for the conditions which it imposed upon them, admittedly because of an anti-social action which they were, at least, theoretically accused of, but not necessarily proven to be guilty of.

Senator HOWDEN: Mr. Winch, if you please, just this question. If we could, as it has been said that we can, get rid of the addicts for a certain amount of time, then the evil would die out because there would be nobody to take up the product of the pushers or the suppliers. The problem you are facing is the individual, who, owing to physical or mental condition, cannot overcome the habit, it becomes a part of himself.

Mr. WINCH: If we can treat him and eliminate the drug habit so far as he is concerned—we have had testimonies before this Committee that it can be done—and if we can do that, then we can make headway with regard to the circulation of drugs, illegal circulation of drugs, because the market will fall and when the market falls there will be nothing. You have to supply an alternative source of supply of drugs.

Senator HOWDEN: That would be the legal suppliers.

Mr. WINCH: It would have to be a legal source of supplies. If not, inevitably he is driven to the illegal source.

Senator HOWDEN: Yes, but mind you, by this time we have assumed that we will have eliminated the addicts.

Senator HORNER: We will have them cured.

Senator HOWDEN: They'll be cured and there will be no market.

Mr. WINCH: Surely. Once you accept the fact that an addict can be cured and the social responsibilities of providing the facilities to effect his cure—

Senator HOWDEN: That is the purpose of this committee.

Mr. WINCH: I hope it is.

Senator HODGES: Mr. Winch, knowing some of your views, would you say that a similar method would apply in the case of alcoholics? Would you, to cure alcoholism, supply them with free or legal doses to over-come their habit of alcoholism? I want to ask you because I know your views—

Mr. WINCH: Well, I am somewhat prejudiced against the use of alcohol, you see, and—

Senator HODGES: Well, we're prejudiced against the use of drugs, too.

Mr. WINCH: I am very, very definitely.

Senator HODGES: I just wanted to know what your attitude was.

Mr. WINCH: I therefore submit for the earnest consideration of this Committee the two proposals as submitted to, and supported by, a large majority vote of the members of the medical profession in this Province, and which the Committee will recall were:

1. The establishment of a hospital for the treatment of drug addicts with a view to their rehabilitation, or, alternatively—no, not alternatively, also:

2. The establishment of legalized medical clinics for the treatment of certified chronic drug addicts for the purpose of administering the minimum amount which will enable them to carry on their means of livelihood and refrain from having to resort to underworld sources of drug supply.

In doing so I would point out that the latter proposal does not contemplate the indiscriminate handing out of drugs to the addict but some form of strict control by personal medical treatment or by prescription, limiting the addict to one particular pharmacist as already successfully operative in some other countries.

The alternative is the continuation of attempted control by increased penalties, imposed mainly upon victims of the habit and rarely upon the major profiteers. This policy leaves the illicit market the only source of supply available to the addict.

In this regard, I would quote Professor A. Lindesmith, one of the outstanding international authorities, and I had hoped that this Committee was proposing to have Professor Lindesmith before it. I quote:

The basic reason for the failure to cope effectively with the narcotic drug addiction are two:

1. the large profits involved in the traffic and
2. the ease of concealing the drug.

The illegal drug trade is fundamentally an economic enterprise, a fact that is often overlooked in the preoccupation with its moral aspects. Viewed from the standpoint of economics, the current efforts of control present a dilemma based upon the well known principle that, with a given demand, a short supply creates higher prices and profits. Suppression of smuggling, insofar as it is successful, inevitably raises prices and profits for those who stay in the business. Hence the attempt to suppress the evil automatically makes the evil monetarily more attractive. The existence of a lucrative underground and uncontrolled illegal trade guarantees the continued spread of the habit.

Senator HOWDEN: Will you be leaving submissions of your evidence?

Mr. WINCH: Yes. I am personally convinced that, with suitable and adequate facilities for treatment, a very worthwhile percentage of drug addicts can be cured and many others kept within controllable limits which would obviate their resort to illicit sources of supply.

We have the choice of a controlled legal supply, with law-abiding citizens, many of whom could and would be social assets, or an illicit market, whose only incentive is profit, as the only source of supply available to victims of a habit which, unassisted, makes them social liabilities irrespective of whether they are in jail or not.

Commissioner Nicholson stated as reported on page 39 of your report: "so long as the demand for illicit drugs exists there will be criminals to supply it. The demand cannot be cured by putting addicts in jail. It can only be met by taking from the underworld the exclusive means of supply, not for the purpose of obtaining the present profit, but to hold—to help the addicts help themselves."

I maintain that drug addiction will never be cured by those who do not believe in the possibility of doing so. A positive, constructive attitude is essential, not only to the addicts but to all those in whose hands the present and future status of the problem is entrusted.

Mr. LIEFF: Mr. Winch, I just wonder if it would be fair to ask you just one question. You seem to have indicated in your presentation that the figures, the tables of convictions, such as put on the record by Commissioner Nicholson and the Minister, are not a good indication of the number of addicts that we have. I wonder if you would have some other method, or some better formula by which we would arrive at a more actual number of existing addicts?

Mr. WINCH: The jail and penitentiary report indicate not only the number of inmates who were convicted for offenses under the Narcotic and Drug Act, but also those who are addicts although convicted for other offenses. You see, I have an analysis of our jails for the last ten years in which I stated, the number of inmates in our jails, who are addicts is far greater, far greater, than the number of those who were convicted for infringement of the Act. So you haven't got a correct picture by merely taking the number of convictions.

Senator STAMBAUGH: Our Federal Department of Health and Welfare have a different method. They know every one that is procuring narcotics in Canada whether it is legal or illegal. If they get it through a doctor or any other way.

Mr. LIEFF: Doctor, we have had this figure of—what is it—thirty two hundred. Would you care to estimate for our information how many addicts there are in the Country?

Senator STAMBAUGH: This table number 1, laid on the record by the Minister, indicates 2,364 criminal addicts, 515 medical addicts, 333 professional addicts, making a total of 3,212 addicts. Would you say that that figure it out very much?

Mr. WINCH: I can only go by the Government's own figures as in their reports submitted to the United Nations.

Senator STAMBAUGH: You'll go along with those?

Mr. WINCH: It's much greater than that.

Senator STAMBAUGH: You think it's very much greater?

Mr. WINCH: I'm sure it is.

Senator HODGES: Are you speaking of convictions or addicts?

Mr. WINCH: I'm speaking of addicts.

Senator HODGES: Criminal addicts or—

Mr. WINCH: I'm not concerned with whether they're convicted or not. My concern is with an addict, an addict!

Senator HORNER: You're quite all right.

Mr. LIEFF: That's right. And the 3,212 includes 2,364 criminal addicts, 515 medical addicts and 333 professional addicts. Your estimate is that it's much higher, is it?

Mr. WINCH: Yes.

Mr. LIEFF: Would you care to—

The CHAIRMAN: He did quote the United Nations—the Canadian information to the United Nations gives five thousand.

Mr. WINCH: Yes, you see, that is the Canadian Government's own report to the United Nations.

The CHAIRMAN: I saw that report myself.

Senator HOWDEN: What difference does a few addicts here or there make, it is still the problem.

Senator HODGES: It is really a question of what we do about it, rather than in the number.

Mr. WINCH: Yes. Even if there's only one.

Senator HODGES: Yes.

Mr. WINCH: Even that one is a social liability. And irrespective of whether society was responsible for his or her addiction it is society's responsibility to help make that individual a good, healthy individual and a social asset.

Senator HODGES: That's what we're trying to do.

Senator HORNER: For the good of society.

Mr. WINCH: Yes, for the good of society.

Senator HODGES: That is what we are trying to do but it's just a question of the method. There are so many differences of opinion as to the method of doing that.

Mr. WINCH: There has been a conviction in the minds of so many that nothing could be done about it except put them in jail, and jail never cured an addict. And I will say it never will, but we have definite proof it has made many.

Senator HOWDEN: But we can't cure addicts without controlling them. They have to be controlled.

Mr. WINCH: Yes, and they will accept that control. The addict who wants to be cured, and it's admitted that they do want to be cured, the very fact that the majority of those who go into Lexington are volunteers, which proves they want to be cured—

Senator HODGES: You mean some want to be cured.

Mr. WINCH: Yes.

Senator HOWDEN: They all must be controlled. Call it jail or call it whatever you like, they all must be controlled in a certain compulsory way.

Mr. WINCH: Yes. There's a control by imprisonment, there's a control by supervision outside.

Senator HORNER: But you are definitely opposed to long jail sentences.

Mr. WINCH: Definitely. I'm absolutely opposed to sending an addict to jail, basically because he's an addict. It's basically because the charge is he's in illegal possession of narcotics. And I meant it. The law has gone so far as to depend upon a microscopic—

Senator HOWDEN: If we change that basis, and put it that we are dealing with the addict from the view point of curing him.

Mr. WINCH: Yes, surely.

Senator HORNER: But long jail sentences are given to the ones who peddle it, is that not so?

Mr. WINCH: Yes, but so many of the peddlers—the “small fry”—who peddle it, do so to get their own source of supply. Just the same as some go for prostitution, some turn to thieving, others go to pushing.

Senator BEAUBIEN: He is a peddler though.

Several Senators: He's a peddler though.

Mr. WINCH: I know he's a peddler. But first of all he's an addict, and his peddling is merely to get his narcotics. You've got to treat him, not as a pusher, but as an addict. And if you cure his addiction you cure his pushing.

Senator BEAUBIEN: How are you going to distinguish between one who is peddling for his own use and the one that really peddles—that's really a peddler.

Senator HORNER: That is the reason the general public is demanding the long jail sentences.

Senator HOWDEN: He only needs to be incarcerated long enough to cure him.

Senator HORNER: If he is a peddler, that is a crime.

Mr. WINCH: No, the one that society is entitled to give a long sentence to is the person who deals in drugs but does not use them himself.

Senator HODGES: Of course, on the other hand, I think they're thinking of the protection of the public in giving peddlers long sentences. It's more primarily designed to protect the public.

Mr. WINCH: But it is not protecting the public by simply putting that individual in jail. That is not protecting the public.

Senator HODGES: Well that's a matter of opinion.

Mr. WINCH: You take him away from society for a period of time, then you let him go back to society again.

Senator HOWDEN: About a peddler who is not an addict, as soon as his market is relieved, he'll soon stop peddling.

Mr. WINCH: Inevitably and necessarily so, there will be no market.

Senator HORNER: The best bootlegger, a hotelman, is a teetotaler.

Mr. WINCH: I understand, sir. No, I don't know.

Senator HODGES: But you put bootleggers in jail though, wouldn't you Mr. Winch? I'd like to put you on the spot there.

Senator HORNER: Mr. Winch, are there some peddlers who are not addicts?

Mr. WINCH: Oh, yes, there are.

Senator HORNER: Well, how would you treat—

Mr. WINCH: Oh, as severe as you like with those. I have no objection. I'm not speaking on behalf of the peddler who is not an addict, but I am speaking on behalf of an addict, irrespective of whether he's a medical man or whether he's an individual who is pushing so he can get his own supply.

Senator LÉGER: Would you admit that an addict should be used the same as an alcoholic, for instance?

Mr. WINCH: Yes.

Senator LÉGER: They should be used the same way.

Mr. WINCH: Yes.

Senator MCKEEN: You said that for an infinitesimal amount of drug on the person he is convicted.

Mr. WINCH: Yes.

Senator McKEEN: Do you think that a man that has any drug on him at all, I don't care how small, would have it on him if he wasn't an addict?

Senator HODGES: Or a peddler?

Senator McKEEN: Or a peddler.

Mr. WINCH: No.

Senator McKEEN: I don't think that the amount makes any difference and I don't think that you could say whether half a grain or a grain would make any difference.

Mr. WINCH: But it is not an offense to be an addict.

Senator McKEEN: No, no, but it's an offense to have possession.

Mr. WINCH: And don't you think it's going to an extreme limit when you convict a person on a microscopic test of a syringe or a spoon or whatever it is. I think you are leaning backwards to punish an individual for an infirmity.

Senator McKEEN: I think it's the wrong offense. I think what they're trying to get at is that he is an addict and for that they're doing it by indirection just the same way as in the States where some of these gangsters, they went after them on income tax. They were really after them because they were gangsters.

Senator HORNER: Isn't it true, Mr. Winch, in most of those cases, there is a lot of collateral evidence surrounding that individual. I don't imagine a person would be just taken that had no suspicion whatever and ever be sentenced because of a microscopic evidence unless there was a lot of surrounding circumstances.

Mr. WINCH: Or, on the other hand, it might be for the purpose of boosting up the number of convictions as evidence of the efficiency of the law enforcement authorities.

Senator HODGES: I think that is unfair.

Mr. WINCH: Well, I'm prepared to be unfair in regard to it because I'm very, very suspicious of it. They go down on skidroads and pick up a dozen or fifty any time they like, and what have they done when they picked them up? Just make a record of so many arrests, so many convictions. And you've done nothing toward cure.

Senator McKEEN: We were told yesterday by the Salvation Army that you didn't find practically any addicts on the skidroad.

Mr. WINCH: Ask the police where they pick them up then.

The CHAIRMAN: We'll have the police here tomorrow.

Senator HOWDEN: If the Government was to decide on a comprehensive method of dealing with this question, then don't you think they would take care of the minor ills?

Mr. WINCH: Yes.

The CHAIRMAN: Any further questions, gentlemen?

We thank you, Mr. Winch, very, very much for being here.

We have another witness this morning but it is now five past twelve. Mrs. MacCullie was to appear. I called you, Mrs. MacCullie, but you happened to be out when the previous witness left.

Senator STAMBAUGH: Is there any indication of how long you might be, Mrs. MacCullie?

The CHAIRMAN: How long would you take, Mrs. MacCullie?

Mrs. MACCULLIE: It would be very brief.

Mr. LIEFF: We have 11 pages here—ten pages—at the average of maybe three minutes a page.

The CHAIRMAN: On behalf of the Committee may I welcome you as a witness.

Mrs. MacCullie has been devoting a part of her life to drug addicts, anonymously.

Mr. LIEFF: Just for the records, Mrs. MacCullie, you are a housewife and I suppose it is fair to say you have had no professional training in this field?

Mrs. MACCULLIE: No, I am a layman in the field.

Mr. LIEFF: And you have developed an interest in it, perhaps, at one time as a hobby but now a real interest in some people who are addicts.

Mrs. MACCULLIE: That is quite true.

Mr. LIEFF: From a layman's point of view.

Mrs. MACCULLIE: Yes, that is true. I would like to make it very clear that I am not speaking for the addicts I have known, nor am I speaking for Narcotics Anonymous. The opinions I express will be my own based on the research I have done on drug addiction and the work I have actually done with drug addicts and their families. If I have learned nothing else about drug addiction, it's this.

Each addict is an individual with individual weaknesses and strength that differ one from another. The causes of his seeking a way of escape from his life through the anesthesia of drugs also differ in each addict and we can't make sweeping statements about addicts—they are all liars, they are all this, they are all that. Each addict is an individual.

Treatment of addicts must be treatment of the addict as a person, not just as part of a group. Obviously, the treatment of a sixteen-year-old girl addict will not be the same as that for a man over seventy, who has been using drugs for almost half a century.

This Committee has expressed a desire to hear as many different opinions on drug addiction as possible, and this is most gratifying. My feeling is that more research should be carried out with the full cooperation of addicts, in their own environment, so that the addict's point-of-view can be made available to your Committee. The research being carried out by Dr. Stevenson and his associates is extremely valuable and a great contribution, and a great step in the right direction.

However, I would respectfully suggest that this research is necessarily limited in a jail setting. I don't think that I could open up my heart in jail and tell them all about myself in a jail setting. The addict in jail and off drugs is quite a different personality from the addict on the street and in his own environment.

Although I have done a considerable amount of study on the drug problem, I admit quite frankly that I knew very little about drug addiction until I became acquainted with addicts in the different phases of their living and at different stages of their addiction. I learned a little about addicts and how they felt and thought when they first came out of jail, and while they were using drugs but were not physically dependent upon them; that is, not sick without them. While they were working and using drugs (and I've seen that), or working and not using drugs. I learned something about how addicts suffered through the withdrawal distress. How they felt when they were home with their families and how they reacted to difficulties that came up in their lives and how they coped with these things.

I certainly don't claim to be an authority or an expert on the lives of drug addicts, but the little I have learned about their lives has been an indication to me that before we set up a recovery program we must have a far better understanding of the drug addict as people. For example, at one time I

couldn't understand how a man could relapse after eighteen years of drug-free living. I didn't appreciate the difficulties of staying off drugs until I saw men and women put up battles to stay off that I would call nothing short of heroic.

I regret that I can't give you examples of this from case histories of addicts I have known. However, I feel most strongly that there are so many things we should know about addicts before we even formulate plans for combatting the drug problem.

We, the public, can't seem to get beyond our feeling that here is an addict, he's doing all these terrible things, someone must be punished. If we can't feel it in our hearts to punish the addict, someone else must be punished, the pusher, the big time racketeer. If punishment would accomplish what we're trying to do—eliminate our drug problem—I would back it, but obviously it is accomplishing nothing. The United States has been practicing this for forty years and they have the largest market for illicit narcotics in the Western World.

What we seem to be most concerned about regarding drug addiction is: One, the spread of addiction. We fear that the tragedy of addiction might possibly reach one of our own teen-agers. We are interested in number two: prevention. If at all possible we want to prevent a new generation of addicts. Three, we want to do something about the big-time trafficker. We want to do something about this man who is making the large profits in drugs. We want him stopped. Four, we want to cut down the criminal activities of addicts who can't support their habits legitimately and indulge in criminal activities in order to pay the tremendous market drugs. Five, we feel that in order to do this, it is necessary to do something about the addicts in our community who are, by example if nothing else, believed to be the spreaders of the habit.

In my personal experience I have never seen evidence that addict peddlers deliberately tried to create new markets. In fact, yesterday afternoon, I was speaking to a seventeen year old boy—I would appreciate it if the press wouldn't use this particular part—who said that one of the reasons he was quitting drugs is he was having a terrible time to score. Addicts on the street wouldn't sell to him. We feel that we must do something about the addicts in our community who are believed to be spreading the habit.

Very roughly for this purpose we can divide our present addicts into two categories.

A. The addict who sincerely feels that drugs are not the answer to happy living and a full life, and who wants to do something not only about his drug problem but his life problem. He is the addict who has a real desire to stop using drugs and be able to live at peace with himself without the anesthesia of drugs. Let us be honest enough to admit right now that these addicts are in the great minority. I have addicts coming to me, telling me that they want to be cured and they come to me for no other reason except that I might be able to help them. But other pressures drive them there. Pressures from the police, pressures from their families, it isn't because they really want to quit using drugs, it is these other pressures that drive them to me.

B. We have to do something about the addict who cannot or will not live without drugs and who probably will, regardless of our personal feelings about him, continue to use drugs for the rest of his life, whether he gets them legally or illegally.

This seems to be our problem—what can we do about it?

Let us examine some of the suggestions that are being made to control drug addiction.

Increased police activity? Well, we have police drives to round up addicts and we manage to imprison a few addicts in each drive. If we don't agree on anything else, we agree that jail is not the answer. Addicts associating with

addicts in jail, as you have heard, tends only to spread addiction. But let's not blame our prison authorities for this. With over-crowded jails we are asking the impossible when we ask complete segregation of addicts from non-addicts. I have actual case histories of addicts who took their first "fixes" in Oakalla prison. Stepped up police activity drives a few addicts out of town temporarily; drives other addicts a little deeper underground, they're going to be a little more careful, but I think we should ask ourselves if this is what we really want to accomplish.

It has been suggested that we have quarantine of all known addicts, and I hope, gentlemen and madam Senator, that just for a moment you will keep an open mind on this. My personal feeling is that we should be extremely careful about taking such a drastic step as quarantine. We should ask ourselves how long it would take to round up and convict in possession of drugs all of our known addicts. Surely we don't expect to send all addicts into quarantine who have a history of addiction but who are not using drugs at the present time. And I know some of these individuals. What about addicts who are apparently unknown to the police, or, if they are known, have never been checked by the police, who are wealthy enough to support their habits legitimately, or who have access to drugs. Do we start a witch hunt to discover these people? Take them away from their families, their professions, their business, put them into an institution where they will be of no further use to themselves or society, or do we have separate laws for the addict who can support his habit legitimately and the addict who cannot.

Senator HOWDEN: What would you do with them?

Mrs. MACCULLIE: I will be coming to that in a moment, senator. And, may I carry on and I'm sure most of your questions will be answered by the completion of this paper.

I must, in this connection, be extremely careful that I do not betray the confidence of the addicts and their families who have put their confidence in me. So, I can only say that these unknown addicts exist and they are certainly not all in the medical profession. I've talked to some of them who are using drugs and living relatively normal lives in their community, in most cases unknown. I have one man whose addiction is unknown even to his wife.

I feel that quarantine is an admission on the part of society that we have failed in our methods of control and treatment of drug addiction, if we can't do anything better than get them out of sight. It is possible that I don't understand the meaning of quarantine. To me it means nothing more than a longer sentence in a special jail for addicts. If we put a man in jail for six months or sixteen years, give him no treatment, turn him loose in society with no friends other than his skidroad pals, no job, no money, no decent place to live,—and we're doing it all the time—what can we expect. Without treatment, other than his forced withdrawal from drugs, he comes out of jail the same man that went in, except that he's a little more bitter and he plans on playing it a little safer and a little smarter next time. How can we even be surprised when he relapses almost immediately. An untreated victim of V.D. would do no better, no matter how many years he spent in jail.

It has been suggested that we have increased penalties for traffickers. Well, we just must punish someone, mustn't we? It's no reflection on the efficiency of the police when they admit that the big-time drug traffickers are rarely caught and convicted. These men are diabolically clever in making sure that they seldom make slips and give the police enough evidence to convict them. They let the underling, the addict peddler, take the chances, and these, not the racketeers who are making the big profits out of drugs, are the ones whom they are catching over, and over, and over again, and putting into jail. Even when we do convict some of the racketeers who are in the drug business for profit only, there is never a stop in the flow of illicit narcotics on the black

market. As long as we have a big market for drugs, and as long as there are tremendous financial gains to be realized in the racket, with few risks involving the top men, it appears that we will have to be prepared to have some rackateers who will take advantage of it.

We seem to be developing a full size problem in Canada. It would seem that we will need a full size recovery program. I hope to live to see the day when there will be established in the larger cities across Canada—this is something I don't believe you gentlemen have heard before—medical centres—where addicts would come for diagnosis by a team of doctors, psychiatrists, psychologists, social workers, and so on. Through interviews, physical and psychiatric examination, blood, urine and other tests, could be determined by this team of experts, not by people like you and I who can say this man can and will be cured, but experts in the field, it can be determined whether the patient is a drug user, the drug used, whether the patient was addicted and the depth of his addiction, whether he was physically dependent on the drug, sick without it, whether he was psychologically dependent on the drug, whether he was in need of medical care, under nutrition and other diseases incident to drug addiction, whether he was in need of psychiatric guidance, deeply disturbed emotionally. The results of these examinations would be the basis for the subsequent medical action, advice, care and treatment of the patient.

The medical centres for addicts could also fill another most urgent need in our communities. I am particularly conscious of this because almost every day I hear from wives or husbands of addicts, mothers of addicts and others, as well as the addicts themselves, asking for advice on their problems and where they can turn for help. Many, many of these people could be helped. I try to do the best I can without facilities, without funds, but this is a job that can't be handled by one person, or even a small group of people. It has come to a point in my home where I actually dread to lift the 'phone from the receiver because there is so little practical help I can offer these people who are in such serious trouble. What would you say to the mother of a sixteen-year-old girl who was using drugs, doesn't want to stop and thinks it's big time stuff? What advice can I give a seventeen-year-old boy who wants to kick his habit—get off drugs and there's no place to send him? What can I say or do to help an old age pensioner whose son will be released from jail and she's asking me how she can help him to stay off drugs? What counsel can I give the man with a family—and this one is breaking my heart right now—who has no police record of any kind, who has been using drugs only two months, and wants desperately to stop, before he loses his job or becomes known to the police.

There are others in Vancouver that I am sure are in exactly the same position, because I frequently get calls from doctors, ministers and other people asking me what can be done to help the addict who has come to them for help. Although we try to do a little to help these people it's a pretty heartbreaking experience to try to cope with their problems, day after day, without facilities, without funds, without any of the things that will help to fill their needs.

If, getting back to the medical centre, after diagnosis at the medical centre it was found that there was a possibility of rebuilding the patient's life, free of the slavery to drugs, he should have the opportunity of being sent to a special hospital—not a special hospital—to a hospital for humane withdrawal of the drugs. Humane withdrawal of drugs! I can't remember any more how many addicts I have helped kick their habit in dirty little old hotel rooms, tourist camps, all sorts of places without medical aid of any kind. I've taken addicts off drugs who have had serious heart conditions, and I've gone through it with them for three, four and five days and I didn't know whether they would live or die, and couldn't get them into a hospital.

This would not necessarily mean a specially built hospital for drug addicts only. From the hospital the patient would go to a rehabilitation centre outside of the city for treatment of his emotional and other problems, plus a program of rehabilitation. Our churches should certainly be encouraged to participate in this program and would be a tremendous help to the patients.

This would be followed by assistance in getting employment for the patient before he left the rehabilitation centre, and comprehensive follow-up treatment.

At first, this part of a general plan would probably cover only a small percentage of our addict population, but to treat this group and not the so-called incurables, would do very little towards stopping the spread of addiction. If nothing was done about the incurables it is likely there would be as many new people starting on drugs on the streets as we would be treating in our rehabilitation centres. If we quarantined all addicts who were eligible for the rehabilitation centres—who weren't eligible—almost all addicts would plead for a chance to go for a cure rather than go on to an island for the rest of their lives. If this happened, we would probably not be getting the addicts in the rehabilitation centres from whom there was the best chance of rehabilitation and the progress of the men and women in that rehabilitation centre who were really trying would be slowed down by these people who were coming only to escape quarantine.

If it was felt by the professional group in the medical centres that there was little chance of the patient living effectively without drugs, his case would be transferred to a practising physician who would receive the case history and continue the treatment in a doctor-patient relationship, working in co-operation with the staff at the medical centre. The patient would also report to the medical centre from time to time for checkup and he would be treated by a private physician.

Treatment would probably consist of psychological treatment along with maintenance dosage of morphine. No attempt would be made to force withdrawal unless the patient reached the point where he wanted to go through the withdrawal and into a rehabilitation centre in order to re-build his life. It's quite possible that this could come about by the doctor helping him to come to a better understanding of the problems that caused him to become an addict in the first place. If dosage was increased to what was considered a dangerous level—addicts are very much like you and I in this point, they don't want to die—the patient could be persuaded to go into hospital for reduction, not complete cure. Patients would not receive drugs to take out of the office, but would receive sufficient drugs to keep them comfortable. In most cases it would be possible for the patient to work and he would, through the help in this medical centre, be encouraged to work and helped to find a job, and so on.

If the patient moved to a different part of Canada, his case would be transferred to a physician in that area.

Such a program as this would take care of all addicts. It would take the addicts out of the hands of the racketeers and put them into the hands of the medical profession where they belong. If there were medical centres for addicts, hospitalization facilities made available for withdrawal, a rehabilitation centre outside of the city, a program of prolonged treatment for the so-called incurable addicts, then and only then would we have increased police activity along with tremendously increased penalties for illegal possession of a trace of narcotics and also for trafficking. Something like twenty-five years for being found illegally in possession of one capsule of heroin, and it would also be necessary to enforce these laws and penalties.

Many addicts feel that drugs are their greatest need in life. Now it's hard for us to identify this with the addict. It's hard for us to imagine how drugs can be your greatest need, but that's the way they feel about it. It seems unlikely to me that an addict would jeopardize his greatest need, a need that comes before his health, his reputation, his home, the people he loves, everything, by peddling drugs for profit or possessing drugs illegally, if he were getting maintenance dosages from his physician. My feeling is that he would be less inclined to indulge in criminal activities and risk going to jail and being deprived of his drugs.

Curious youngsters, these kids that I run into absolutely break my heart. The youngest I had was a little girl of fourteen years who was using about thirty dollars worth of drugs a day. If we possibly can, I think we should do something about these youngsters, the new generation of addicts. And my feeling is that curious youngsters who like to try drugs a few times just to see what it's like, and become addicted, would probably report to the medical centre sooner because of the expense and difficulties involved in supporting their habit. The sooner they reach the medical centre, of course, the greater their chances would be of their being rehabilitated. Now we don't catch them for two or three years after they're started using drugs. It's been said that such a program of controlling addiction would be considered condoning an evil. Well, is this because we've been educated to think of drug addiction either as a thing of horror or, to youngsters, a very exciting, new forbidden fruit.

We treat V.D. as a medical and social problem primarily perhaps because our education has been directed towards accepting it more or less unemotionally. We don't condone V.D., by accepting it as a medical and social problem. We still don't think in our society feel that it's a very nice thing to have V.D. I feel most strongly that our attitude and our education on drug addiction could well be patterned along the lines we have adopted with V.D.

In summary, I tried to point out, one, the need for medical centres in Canada for the diagnosis of addicts which could serve also to counsel the families of addicts and I hope carry out a program of research on drug addiction. This medical centre could also serve to direct a program of education as well as assist the physicians who are treating drug addicts.

Two, the urgent need for hospital facilities, not necessarily an especially built hospital, but hospital facilities for the purposes of withdrawal.

Three, the need for a treatment and rehabilitation centre, outside of the city, for those who truly desire to rebuild their lives and for whom the professional workers would feel there was some hope for success.

Four, the need for prolonged treatment of so-called (I keep calling them) incurable addicts.

Five, increased police activity and tremendously increased penalties for possession and trafficking if, and only if, all of the other steps in this program were put into effect simultaneously, all at one time.

Six, an educational program on drug addiction, patterned on that of V.D.

Seven, the urgent need for more research with the full co-operation of the addicts in their own environments before any plans, even my own, are put into effect.

In conclusion, I would like to say only that for the past five years I've studied drug addiction; I've worked with addicts and their families, to the very best of my ability. This has been done at my own time and at my own expense and my appearance here before your Committee will permanently terminate my work in this field.

I am deeply grateful to the many wonderful people who have helped me in this work, but I'm going to be very happy to return to a full-time job of being a mother, a wife and a homemaker.

Thank you.

Senator HOWDEN: Just a moment, please, Mrs. MacCullie. You have given us a most comprehensive and favourable paper.

Now, you seem to be prejudiced against so-called isolation, but it is not isolation that we have in mind. It is the same idea as a tubercular sanatorium, where addicts could go and be given the first necessary steps in cure and then the rehabilitation centre, which you speak about, that is, I think, in the mind of this Committee too. But that has to be isolated, if not, there would constantly be intercourse between the rehabilitation centre and the trafficking drug fiends.

I am in favour of isolating, absolutely isolating them, and as they graduate from that isolation stage let them be returned to society again. What would you think of that?

Mrs. MACCULLIE: I would think, sir, when are we going to determine when this man is cured, first of all.

Senator HOWDEN: It would be under medical supervision, of course.

Mrs. MACCULLIE: It will be under medical supervision, but with their—I can't honestly say, that I have ever seen a cured addict. Now, this is going to conflict with what other people have said, I've never seen a cured addict. I have never seen an addict without some symptoms. I have addicts who are not using drugs. I know addicts who haven't used drugs for seven years, eight years, ten years—

Senator HOWDEN: Why do you still call them addicts?

Mrs. MACCULLIE: They are still not cured. The best I could say for them is that their case is arrested. They are not using drugs—their case is arrested—but these people still have symptoms of addiction.

Senator HOWDEN: Then what more can we do for those people? If we don't put them in a rehabilitation centre of some kind and give them gainful occupation which they are enjoying.

Mrs. MACCULLIE: What I am trying so hard to do is to point out an addict to you as an individual. I know addicts that should be—

Senator HOWDEN: My dear young lady, I am a medical man of over fifty years experience and I have had addiction in my own home.

Mrs. MACCULLIE: Have you, sir.

Senator HOWDEN: Yes. I have had addiction in my own home so they can't tell me anything about addiction that I don't already know.

Mrs. MACCULLIE: Then, you will appreciate the fact that there are addicts who should be in an institution.

Senator HOWDEN: Sure.

Mrs. MACCULLIE: Be locked up.

Senator HOWDEN: Many dozens of them.

Mrs. MACCULLIE: But you will also, because you have had this experience with addicts, know that there are addicts who would actually be hurt by institutional living.

Would the press please exclude what I am going to say now? This young boy that I have now, seventeen years old, he has kicked his habit for one week. But that boy's problem isn't drugs—it's obvious to a layman like me that it isn't drugs. He has a new stepfather. He had him right in the years when he needed a mother. He resented this stepfather and what that boy needs right now is a home and a mother.

Senator HOWDEN: What are you going to do with this boy that you're talking about?

Mrs. MACCULLIE: I'm certainly not going to put him in an institution. I'm going to put him into a family that will love him and look after him. I'm not going to lock him up with a bunch of incurable addicts.

Senator HOWDEN: Can you get such a family? Most families resent intensely the idea of even touching the drug habit.

Mrs. MACCULLIE: I'm going to do my very best to get that boy into a home where they will understand and help him.

Senator HOWDEN: It is to be hoped that you will succeed because your activities are most laudable.

Senator HORNER: Fourteen years of age and sixteen, it seems there has been a great lack of that old woodshed and the strap.

Senator HOWDEN: I haven't any more to ask you but I want to congratulate you for your very fine submission.

Mrs. MACCULLIE: Thank you very much.

The CHAIRMAN: Thank you, Mrs. MacCullie, for appearing before this Committee.

The Committee adjourned until 2:00 this afternoon.

AFTERNOON SITTING

TUESDAY, April 19, 1955.

The Committee met at 2.05 p.m.

The CHAIRMAN: Honourable Senators, there is a quorum of the Committee present and time is going along and I would like to start.

This afternoon our witnesses come from the Vancouver Community Chest. We have been presented with certain documents by Mr. Hill who informs me that Dr. J. G. Foulks is going to present the case.

I would appreciate Dr. Foulks coming forward.

May I welcome you on behalf of the Committee, doctor.

Dr. FOULKS: Thank you very much. I would like, sir, if I may, Mr. Chairman, and Senators, to begin by reading a brief which has been prepared by the Secretary of the Standing Committee of the Prevention of Narcotic Addiction of the Community Chest and Council of Greater Vancouver, and to read it on their behalf. If I may, upon completion of that, I would like to add a few informal comments and personal opinions on my own responsibility prior to the general questioning.

Speaking for the Community Chest and Council, may I congratulate this Committee on undertaking its investigations into the problem of drug addiction. I would also like to express my pleasure for having the opportunity to appear before this Committee and report to you the activities of the Greater Vancouver Community Chest and Council's Committee on the Prevention of Narcotic Addiction. I have had the privilege of chairing this Committee for

the past two years, and together with Mr. Hill, the Committee Secretary, I would like to put before you the results of four years study and activity on the part of Vancouver citizens who make up our Committee.

For the record, I have attached to my written statement the names of the Committee members who have taken part in this work since 1952 and you will note that these names include many leading citizens in our community. Some of our most influential organizations have participated—among others—Vancouver Council of Churches, Vancouver Trades and Labour Council, Canadian Congress of Labour, Vancouver Medical Association, Junior Chamber of Commerce, Vancouver Parent-Teacher Association, and the Vancouver Board of Trade.

These people have joined in the work of this Committee because they have been very thoroughly impressed by the seriousness of the narcotic addiction problem in this country and particularly in this City. The evidence that you have already received establishes that Vancouver has the unhappy distinction of being the centre of drug activity in Canada and of being the City with the largest number of addicts of any locality in this country.

The Community Chest and Council instituted this Committee in April, 1952. A report was made in July, 1952 which enjoyed wide circulation and was endorsed by many leading community organizations in this country. This report stimulated a wide-spread concern which resulted in much of the activity which has since been undertaken in Canada in regard to narcotic addiction. Copies of the report, "Drug Addiction in Canada—The Problem and Its Solution" have been submitted here.

The CHAIRMAN: Copies will be presented afterwards.

Dr. FOULKS: I would like to read for you the conclusions the Committee came to in this original report. They are:

1. Narcotic addiction with its malignant effects is increasing in Canada and that it is increasing especially in younger age groups.

2. Incarceration of addicts will not solve the problem of narcotic addiction or trafficking.

3. Narcotic addiction is a medical problem with definite psychiatric implications.

4. Any plan for the control of narcotic addiction should be opposed unless it is comprehensive enough to involve all aspects of the problem, as failure of an inadequate plan would jeopardize the trial of any future program.

5. The control of manufacturing, wholesaling, peddling and illegal possession is a legal problem.

Other conclusions have since been reached by the Committee and these will be dealt with later. It should be emphasized that when these conclusions were reached in 1952, they stood in direct contrast with the prevailing attitudes toward the control and elimination of the drug traffic at that time. These were, briefly, that addiction was a legal problem which could be handled by appropriate legislation and vigorous enforcement.

The Committee made five recommendations. The first of these urged a program of adult and youth education concerning the dangers of narcotic addiction. (I would like to comment on what has developed in regard to each of these recommendations as they are raised). In reference to education, the Committee since making its original recommendation has gone into the question and found much conflicting opinion as to whether high school children should be instructed in the dangers of narcotic addiction. As a result, no active program has been undertaken in relation to school children; but the Committee,

through its sub-committee on Education, has since 1952 carried out a very active program of adult education. We have found that many organizations in our City have become concerned with the problem of drug addiction and have turned to us for factual information regarding the problem. We have met these requests by making available to our civic groups and organizations qualified speakers connected with our Committee and in so doing we feel that we have carried out a worthwhile educational project in this City.

Turning again to the question of education for youth, I know you will be interested to hear—you may already know—that the School Board in this City is now carrying out an extensive investigation into the pros and cons of giving information on narcotics to school children. The members of the School Board are obtaining information from numerous school programs in the United States where this question has been approached and I feel that their study will result in some very practical answers to the question of educating our school children in respect to the hazards and pitfalls of narcotic addiction.

Perhaps the main recommendation which the Committee had to make in 1952 was connected with the medical treatment and social rehabilitation of drug addicts. This recommendation was in line with the Committee's conviction that the drug problem is a medical, social and legal problem, rather than just a legal problem. It was proposed that some type of an experimental treatment and rehabilitation program be set up which would possess an extensive follow-up program. It was envisaged that this approach to the treatment of addiction would have three major components—one being medical withdrawal—the second being the application of rehabilitation techniques within the Centre which would be designed to help the addict re-establish physical and emotional well being and the third, an active follow-up program in the community where he would be helped to make contact with the various resources which are necessary for the social adjustment of any person in our community.

Following on this original recommendation, our Committee has developed detailed plans for the establishment of an experimental rehabilitation centre which would be located in or near the City in order to take advantage of the resources necessary for rehabilitation. The Centre's program would be offered to no more than twenty-five people to begin with and these would be volunteers. The patients would be drawn either from Oakalla or the community, and need not all be criminal addicts.

Two kinds of programs would be offered; one for men and one for women. For the men, a small residence would be established to accommodate approximately fifteen persons and the addict wishing to give up his addiction would take up residence there for periods up to six months. During this time the addict would have the opportunity of becoming well acquainted with the staff who would be trained social workers. Gradually as the addict showed readiness to accept employment or retraining, these resources would be made available to him by the agency staff. The main function of the staff would be to make available all the major resources of the community which would help the addict to rehabilitate himself. At the same time, through his personal relationship with the addict, the staff person would do everything within his skill to help the addict break off his former ways and associations. It would be expected that, after obtaining employment, the addict would be able to remain in the Centre for some time and look upon it as a home base where he could return from time to time even after he had officially left the centre.

For the women the program offered would be very similar but the accommodation would take the form of foster homes rather than residential centres owing to the fact that most women addicts are or have been prostitutes, making it inadvisable for them to be grouped in any large number. They would, however, receive the same help to become re-established in the community through re-training and employment.

The Committee's present proposals include the provision of medical withdrawal in general hospitals for those addicts who have not been in a penal institution. In this Province the establishment of such treatment would involve amendments in the Regulations of the British Columbia Hospital Insurance Service, since at the present time no addict is accepted in a general hospital in British Columbia merely for the purpose of withdrawal. If these Regulations were to be altered, it would mean that before an active addict were accepted into the rehabilitation centre, he would be admitted to an acute hospital and given withdrawal treatment under medical supervision before being admitted into the Centre.

The treatment proposals I have just outlined were presented to our Provincial Government last December in the form of two briefs (copies of which I have provided for each member of this Committee) and we have received assurance from the Government that it will embark on some type of experimental rehabilitation program for drug addicts; but, we have not yet been informed as to the extent the Government's program will follow the details of our suggestions.

I should like to emphasize that, in making these proposals, the Community Chest and Council Committee is following a principle that it feels is of extreme importance. This is that no extensive program for the treatment of drug addicts should be established by any level of Government until experiment has been carried out with the most promising techniques for the treatment and rehabilitation of addicts.

I think it is fair to say that no one is prepared to come forward and state with authority that they know the answers to the treatment and rehabilitation problems connected with addiction. It is the observation of our Committee that even large-scale and costly programs of treatment, such as those being carried out at Lexington, Kentucky and Fort Worth, Texas, in the United States, have had only limited success in the rehabilitation of drug addicts. We therefore feel strongly that our activity should be carried out on a small scale initially lest the various levels of Government become committed to programs which may show unsatisfactory results. We also believe that the administration of such experimental programs should be flexible enough to permit radical changes if it should prove necessary. We are therefore proposing a scientific experiment rather than a complete answer to the problem of addiction and we feel this is the only logical approach.

For this reason the Committee is of the opinion that at least the initial stages in setting up programs for the treatment and rehabilitation of addicts should be carried out by private societies under the control of citizen boards. These societies would receive financial assistance from the appropriate levels of Government, and Government representatives would in turn be appointed to the Society Boards. Private financial donations to the work of the Society would also be encouraged. The principal thought here is that a private society would be able to carry out experimentation and research in the methods of rehabilitation and treatment of drug addicts in a thoroughly flexible manner not usually possible to departments of government.

The third original proposal of the Chest and Council Committee suggested that the Federal Government be urged to modify the Opium and Narcotic Drugs Act to permit the Provinces to establish narcotic clinics where registered users could receive their minimum dosage of drugs. I should like to report, first of all, that the Committee has not undertaken any activity to forward the establishment of such clinics. Our members recognize that there are serious questions and practical problems in regard to the suggestion and the current attitude of the Community Chest and Council Committee is that this proposal should be held in abeyance until other methods of dealing with the problem have been tried. The Committee, however, has not abandoned this proposal.

To make one further point in regard to this suggestion—the Committee's original recommendation did not, at any time, include the idea of handing out drugs to addicts over the counter on a "cash and carry" basis. The original proposal was restricted to the idea of drugs being administered within the clinic by professional personnel. For the purpose of avoiding controversy, it should also be made perfectly clear that the administration of drugs to addicts under medical supervision was to be carried on only in conjunction with other well-developed services for rehabilitation. The Committee has never proposed the legal administration of drugs as an exclusive program. Finally, the Committee is still largely of the opinion that if other methods of rehabilitation are tried and prove without value, then the proposal of legal administration will have to be re-examined. For this reason, we would be greatly interested if exact first-hand knowledge could be obtained of the methods employed to treat addiction in Great Britain.

The fourth of our original recommendations had to do with the increase of penalties under the law dealing with trafficking in narcotics. The Committee submitted a brief to the Federal Minister of Health and Welfare in connection with proposed amendments to the "Opium and Narcotic Drugs Act, 1929". This brief was submitted on December 2, 1952, and essentially asked for heavily increased penalties for major traffickers and that the law be written so as to distinguish between these persons and the minor trafficker. As you are aware from testimony previously submitted to you, this recommendation has been realized to some extent by means of amendments to the "Opium and Narcotic Drugs Act" during the past year which now provides a maximum penalty of fourteen years for the offence of trafficking in drugs. This increase of penalties for trafficking is gratifying to the members of the Committee who feel that the legal side of the narcotic problem definitely should not be minimized and if anything, that law enforcement efforts should be stepped up over present standards, particularly against traffickers and larger operators. The intentions of the original report of the Committee will not be met however until the person who is primarily an addict is regarded by law as a medical and social problem rather than a criminal.

In addition to the proposals I have just outlined, our Committee has been engaged in other phases of the problem since its termination in 1952. I would like to outline just one of these in connection with the establishment of the Research Project at Oakalla which is now being directed by Dr. George Stevenson with the help of the Federal and Provincial Governments and the University of British Columbia. The history of this project illustrates what can be accomplished by a citizen committee which is deeply concerned with a problem in the community. Following the publication of the Committee's original report, a conference was called by Federal authorities which included Provincial and Community Chest representatives. At this conference a suggestion was made that what was needed more than anything else was a good research program which would study the causes of addiction and suggest suitable remedies. Following this conference, the Chest Committee set up a sub-committee on Research which developed a tentative outline for a research project. The sub-committee discussed this outline with officials of the University of British Columbia and requested that a more specific program of research be developed under University auspices and that the University apply for financial support for the project from the Federal Government. As a result, a University Narcotics Advisory Committee was set up resulting in the establishment of the present research project at Oakalla.

It is unfortunate, perhaps, that the final results and conclusions of this study will not be available for another year or more. Nevertheless, we feel that a factual scientific enquiry into the nature and causes of addiction in this area will contribute greatly to the eventual solution of the narcotic problem.

In closing I would like to present to you the conviction of the members of our Committee, namely, that drug addiction is not an isolated evil but rather is a symptom of personal disturbance which may take many other forms of expression such as alcohol addiction, general delinquency and anti-social behaviour of all kinds, and that these forms of disturbance are in turn the result of unsatisfactory human relationships, particularly in the individual's earlier experience. Candidates for drug addition are made—not born—and anything we can do to strengthen family life and eliminate the forces in society which tend to undermine our families will be truly a blow against drug addiction and will constitute prevention of addiction in the truest sense.

Now, that, sir, completes the formal presentation on behalf of the Community Chest Committee. I would like to add a few informal comments of my own or perhaps some comparisons between the approach made by our Committee and the proposals as made by some of the proposals advanced by other individuals and groups.

I am sure that your Committee has been impressed with the variety of the scope of the various types of proposals which have been made. And I think that each of these suggestions reflects to a large degree the experience and the training and point of view of the persons advocating it.

I believe that theoretical objections and practical flaws can be found in almost each of these proposals and final answers will not be derived, I believe, from analysis of opinion, but from actual validation in practice. The proposals, I believe, have been divided into two main categories, roughly, depending upon the attitude taken toward the curability of addiction. Those who are pessimistic and believe that addicts by and large are incurable in turn generally offer one of two types of proposals. On the other hand, the suggestion is made for isolation and incarceration—a somewhat punitive attitude on occasion, or at least the protection of the community—by placing the addict in quarantine; or, on the other hand, the legal sale of drugs, stemming largely I believe from the humane motivation but stressing more a permissive attitude toward the use of drugs. The problems of the pros and cons of legal sale have been reviewed very extensively in the article which Dr. Stevenson has submitted to you.

I believe that if the hope of cures is forsaken, that ways could be found to circumvent or solve the various practical problems which are associated with these proposals. However, I think it is not profitable to bicker back and forth about these practical details as long as the major issue of the point of view to be taken remains unsettled. I think that one accepting the viewpoint that this is an incurable condition is inevitably faced with something of a moral dilemma between these two general types of proposals, whether on the one hand addicts are to be jailed for more or less indefinite periods of time, a procedure which I feel they might think rather discriminatory in view of our tolerant attitude toward alcohol addicts whose addiction is certainly more extensive and I think more damaging and serious problem to the individual and the community in many respects than is drug addiction, other than the crime associated with the taking of drugs. Or, on the other hand, the dilemma of considering giving drugs to individuals, catering to their indulgence as it were. It is very difficult for a medical person to resign himself to.

Furthermore, I think that following either of these lines, as an extensive effort to deal with the problem, might impair or interfere with the treatment and rehabilitation programs. Certainly that possibility exists, I think, as long as these programs are largely undeveloped and untested.

It is these considerations which have motivated our Committee to defer consideration of this type of problem of how we stress the point of view of treatment and rehabilitation. I for one, and I think many members of our

Committee would go along with me, am unwilling to accept the point of view that drug addiction, or any other addiction for that matter, is incurable. I personally would like to very heartily endorse the viewpoint expressed in that regard by Warden Christie, this morning. A medical scientist is reluctant to accept any disease as incurable, there are just diseases which we do not as yet know how to cure. And we have certainly not attempted to put all of the force we could into efforts to handle the problem of drug addiction, along the lines of treatment and rehabilitation. In addition, I think we need more extensive study of the methods which might be used in treatment and rehabilitation. It is this belief that goes along with the program we have proposed for an experimental program in treating and rehabilitation which would have to be, as we have stressed, a very flexible program.

Such questions as where should a centre be located—in a city or out in the country—how long should it last—must it be preceded by a period of lengthy institutional care—how long should such institutional care last—can that institutional care under favorable circumstances be by-passed, or short circuited. We have laid great stress on the follow-up aspect of rehabilitation, one which has, by and large, been neglected, or which for practical reasons has not been extensively undertaken insofar as we know in any other effort to deal with this problem along these lines.

The question of compulsion which has been discussed I think was placed in a very good light again by Warden Christie this morning. You cannot cure an addict who does not wish to be cured. You may, however, keep him under control while you try to persuade him that he should wish to be cured. I think this is the distinction which comes with regard to this compulsion and voluntary question.

The degree of success which may be achieved in a treatment and rehabilitation program in turn may help point the direction towards steps which should be taken towards the prevention of drug addiction. In every case, I think, careful testing and experimental techniques will be required to show us the way. It is a complex and a difficult problem. We're not going to find any easy, simple solution or panacea, I do not believe, and I think the only safe approach is one which takes a long range viewpoint and works deliberately towards a careful solution and is not diverted or intimidated prematurely by some of the early difficulties and pitfalls which may be encountered.

The CHAIRMAN: Two questions, doctor. One is regarding the experiment that is being tried out on children. Have you any information regarding that?

Senator HORNER: Investigation by the school authorities?

The CHAIRMAN: Yes, investigation by the school authorities on children—have you any information regarding this?

Dr. FOULKS: I would say, I have met informally and had discussion with the School Board about the pros and cons of the question, as I believe have others—Dr. Stevenson. I'm not prepared to speak in their behalf as to just what they are planning to do. Their minds were not made up at the time we discussed their plans with them. I do know that they are very intensively investigating what has been done in other cities on this continent in regard to this problem and weighing the possible advantages and disadvantages of some type of program of handling in the schools.

The CHAIRMAN: Might it not be dangerous to tell the children—

Dr. FOULKS: I think they are certainly well aware of the dangers and risk involved and have a very conservative approach to this problem. I think, however, that the principal (again I am expressing a personal view on this question) problem is, are these children going to be exposed to narcotic drugs or are they not. If they're not, there is no point in talking to them about it. I

think their curiosity is plenty aroused by what they read in the papers and is not apt to be aroused by a carefully planned discussion of certain hazards and dangers, properly carried out. If the children are going to be exposed to the temptation of narcotic addiction I think they should be prepared in every way possible to understand the dangers that are associated with it. Just how this can best be carried out is a technical problem for educators.

The CHAIRMAN: Another question has to do with your last suggestion. You mention that the problem has probably been brought more up-to-date than was submitted in 1952. It is difficult to see how some ideas carry and others don't. But I know the idea of free drugs was taken up like wild fire. I must have received at least fifty letters by people who have read your document on free drugs and telling us there is the cure. Just follow out the British system and give them free drugs and you'll cut out the traffickers at the top and it's all over. Now, you're modifying the statement—after you've dug into it. I know I was impressed, speaking personally, when I read it, but after I began looking deeper into it I wasn't so impressed. And probably like myself your association has changed their views too.

Dr. FOULKS: I would just like to say this about it. Personally, I don't want to dodge the issue. I have expressed my personal views. Of course, I could by saying that I did not join the Committee until after this report had been prepared and my own views have evolved gradually. I had a pretty open mind on this question when I first joined this Committee. I might say in all fairness that there are members of our Committee who still very strongly feel that this is the thing which should be done. There is no unanimity of opinion in our Committee on this question but we have agreed that it is a type of approach which should be deferred for the time being until every conceivable effort is made to see what we can do at the present time with treatment and rehabilitation.

Senator HOWDEN: How long do you suppose that time will take?

Dr. FOULKS: I think it will take a number of years and I am not prepared to say exactly.

Senator HOWDEN: This Committee, of course, is seized with the immense importance of this subject and we would like to take back to the Senate some—and we will take back to the Senate—some certain very definite impressions that we have received. I personally feel that the less time that is allowed to elapse, until we get going at something, the better. A matter of years seems a long time.

The CHAIRMAN: I'm just wondering, doctor, when I put the question to Doctor Foulks, I'm just wondering if it is the proper place to go, as a criterion, to Great Britain. Great Britain doesn't use the drugs we use. They have no problem. And yet Great Britain's system has been thrown to us as a successful cure.

Senator HORNER: We're prohibiting heroin from coming into Canada now, aren't we doctor?

Dr. FOULKS: Yes.

The CHAIRMAN: You're what?

Senator HORNER: There has been prohibition issued against the importation of heroin. But the question I would like to ask Dr. Foulks, and I suppose his Board of Trade, there has been no reason advanced—they say it's not coming through the American border, we were told even it wasn't coming in by ship—why Vancouver? Would it be, as scientists have told us, that weather has a great effect on animals and human beings. Your Board of Trade wouldn't

agree it was the climate here in Vancouver, I suppose, but still there's some cause and there may be some lack in your climate or water, or something here that perhaps creates that unusual craving. Perhaps the Prairies would be more healthy.

Dr. FOULKS: I would like to, if I may, comment on some of the questions that have been raised. First of all, sir, in regard to the question of time, I agree that it seems very hard to say we're not going to do anything about the problem until a number of years have lapsed. Personally, I would strongly endorse any and all efforts as vigorous as they can be made to undertake programs of treatment and rehabilitation, employing all the resources that we can to guarantee that they'll have the best chances at success and not stinting on the finances, the skill of the staff, and so on, would be required to give them a good show.

I think it would be unwise to go into other possible solutions to the problem, such as large scale incarceration or legal sale, until we have a better idea of what we can now accomplish through treatment and rehabilitation. It's just the kind of thing that takes time before you know what the answers will be. It's just the same with the polio vaccine, for instance, where an experiment had to be carried out before larger scale attempts were made to deal with the problem.

There were some other questions I wanted to handle.

Senator STAMBAUGH: Climate?

Dr. FOULKS: The question, why we have the problem here in Vancouver. I certainly don't know the answer to this question. And the question of Great Britain. What we call attention to is the fact that this frequently is cited—that there is a difference. I think that every effort should be made to examine the experience of Great Britain and to see in what ways it compares with our own. There may be no comparisons at all. The way in which they handle drugs may not explain at all the experience that they have. There may be other factors such as the degree of delinquency that they have.

The CHAIRMAN: And the kind of people.

Dr. FOULKS: Yes, and I think that we have to realize that our own problem, if we're going to understand it, is that we'll also have to understand why it rises and falls during various periods of time and that sort of thing.

Senator HORNER: Right at that point there is a question. Now, one would have thought (we've been told about underprivileged, difficult times), if difficult times and great alarm and unrest would have started people using drugs, then England would have started during the war. But apparently—

Dr. FOULKS: I think that stress alone certainly cannot—we're thinking in a larger scale of terms—stress alone cannot be the only factor; morale must certainly be an important element there too. And that probably varies in different—

Senator HOWDEN: Since England is a staid and settled community, and has been so for many hundreds of years, and that this is a pioneer settlement, with a constantly changing community, and a number of—what shall I call them—adventurers, if you like, constantly coming in and out of the place, this place is subject to a spread of “un-legal” intemperance, if you like, which has been in the past on hand at every new, pioneer place.

Dr. FOULKS: This may very well be an important aspect to the problem here. Although, when you see the growth of addiction in a number of urban centres in the United States, you can't draw the line between those that are more of pioneer frontiers than others. I think the question of stability, of long range tradition, may be a very important factor in the British scene. I just think that at this distance it is hard for us to get the total picture and

we certainly don't get it from any one individual any more than you could get the picture of the problem of addiction in Vancouver from any one individual whom you could talk with here. You have a spectrum from a lot of different people.

Senator McKEEN: Have you any figures on how this problem has dropped or whether they had a larger problem before they started this legal sale? Has this decreased the addiction in England?

Dr. FOULKS: I have never seen any figures of how much it has dropped since they started this legal sale in Great Britain at all. I don't know that they have legal sale in Britain. I don't believe there's any legal authorization for the sale of drugs.

Senator McKEEN: Well, have they less—

Dr. FOULKS: What we hear rumors of is that the regulations are honoured in the breach rather than in the observance, sometimes. If this is true, it is not the thing you will get from official statistics or necessarily from the Home Office. It is the type of thing you might get from individual physicians who practise addicts. It is this type of consideration that makes me think that the best information would come if a group of you Senators, perhaps, might get some first-hand information about it, or send some of the experts from the Department of Health and Welfare over there to look around and talk to the various people.

The CHAIRMAN: We expect to have Mr. Walker, the British Delegate to the United Nations Narcotics Committee before us in the month of June.

Dr. FOULKS: Well, that would be helpful, but I still think that sending observers would be the best way to get the greatest amount of information, and I'm sure you could get volunteers from Mr. Martin's Department who would be glad to undertake that task.

The CHAIRMAN: Doctor, would you care to say a word about the program of adult education as mentioned by you? The Committee on Education, you say, has, since 1952, carried out a very active program of adult education.

Dr. FOULKS: I don't want to exaggerate this, but it has not been an extravagant program at all. An ambitious one but a consistent one and we have supplied speakers for various organizations, Community Chest, Kiwanis, Kinsmen, and so on, on occasion to talk to them about this problem, and have helped in this way to try and keep the community abreast of the real nature of this problem and the type of perspective that we have on it. I think in this regard (and I speak from private opinion and personal experience) I think we owe a debt, in some respects, to our press which endeavours to keep the community aware of the problems with which it is faced. I think sometimes contradictions arise in keeping the community soberly and correctly informed about these problems in relation to the headlines and the sensationalism that sometimes creeps in.

The CHAIRMAN: You can say that again.

Dr. FOULKS: I know from my own experience that this could happen very quickly and easily.

Mr. LIEFF: Did you overlook parent-teacher associations, or do you go to them?

Dr. FOULKS: No, they have been included in this adult education program.

Senator GERSHAW: Mr. Chairman, on page three, Doctor Foulks suggests that fifteen or twenty-five persons should be used in the experiments. I would like to ask him if he considers that an economic unit. That is, a staff, an especially trained staff, would have to be employed to carry out the rehabilitation program and would that be the number of persons a trained staff could supervise effectively?

Dr. FOULKS: I think we thought, sir, in terms of the economy in setting this up, a group which could be conveniently handled in a single individual housing unit which could perhaps be obtained by rental and not requiring large capital outlay of expense, and one which would be small enough at the beginning so that the staff could give the most intensive assistance and care to. We wouldn't want the thing to fail to show what could be done with a very intensive and skilled program. In this regard, I think you'll have to make certain (as Warden Christie pointed out to you this morning) that the salaries we are able to offer will be such that we will get the best people. We'll also have a problem of seeing that we can get people who will have some security as future employment if this is a short term experiment. There are serious problems to be worked out.

Senator HOWDEN: Don't you plan on incarcerating these people?

Dr. FOULKS: No. These are people we expect who would come to us from either one or two sources. They would be the people who have recently been discharged from the prison or penitentiary and would therefore not have been on drugs during that interval, or people coming from the community who say, I want to get off of drugs. Now there are people in this category and we believe these are the best people to start with because they already have the motivation. We don't have to sell them on it.

Senator HOWDEN: Do you think you could depend on them?

Dr. FOULKS: We would have to find that out. We can say this, that some of these people want to get off of drugs badly enough to go through the pangs of withdrawal and stick it out. I recently saw a woman who did this on a completely voluntary basis and this is tough. To be in a place where she could get up and walk out at any time, and to stick it out, she had a rough time of it. So there are people who want badly to get off drugs and to stay off drugs. They need a lot more help than they have been offered thus far. We're going to try to see what we can do to offer them this help.

Senator HODGES: I noticed in your submission in connection with the rehabilitation centre that you say that they could take up residence there up to six months. Do you think that would be long enough?

Dr. FOULKS: We're flexible on that point. This is given as an estimate and it's elastic. We would like to take people who have been off of drugs for a period of time who show a good motivation, and to offer them protective environment from which they can gradually be integrated back into community life. This is the reason that we are being daring enough to try this program right in the city of Vancouver, which may have disadvantages, and to try it as a group unit which may also have disadvantages.

Senator HODGES: The point I'm making is, you think it would be possible within six months.

Dr. FOULKS: We hope that it may be and we'd like to see if we can integrate people in within this period of time. We may find, as we go along, that this seems more risky than we want it to be, and we may have to spread it out. We don't know the answers, we're going to try to find them.

Senator HODGES: It conflicts with some of the evidence we've heard, where people seem to think it's going to take much longer than that.

Dr. FOULKS: The opinions vary. I think the people at Lexington say eight to nine months—or something like that—in an institution of that sort. Well, we're trying to by-pass, to some extent, that type of controlled institutional treatment. We're groping our way along in this regard.

The CHAIRMAN: Have any of your members visited Lexington?

Dr. FOULKS: Of our Committee, no. I think that it would be very important for us in selecting staff to try and see that they have the opportunity to

visit places. Chicago has had a very interesting experience in this regard too. I believe Dr. Roberts mentioned that in his testimony to you, and I think it would be very helpful if you could get some of the people from that Chicago experiment to testify with regard to their experience. They've tried to do something in the community but not in the protective residence environment, sort of on an out-patient basis. This is difficult to do as well. They've had some success but a lot of failure. I don't know the details of their degree of success. I think it would be interesting if we could get that.

The CHAIRMAN: Any other questions from the Senators? If not, doctor, I thank you sincerely for your visit with us.

We will now call Dr. Ranta. May I welcome you, sir, on behalf of our Committee. Doctor, will you proceed.

Senator HORNER: You are from the Community Chest, also?

Dr. RANTA: Yes, I am from the Community Chest.

Mr. Chairman, ladies and gentlemen. My background in the narcotic addiction problems is from having been the Chairman of the first committee of the Community Chest and since that time I have been associated with the Community Chest in this problem and I am also the Medical Director of the Vancouver General Hospital where I come in to, not frequent, but occasional clinical contact with the actual addicts themselves.

We have a very large out-patient—at least, emergency service—at the General Hospital and we get the cross section, as it were, of Vancouver coming into the emergency service and consequently we come into contact with a number of the addicts. We are also faced with the fact, which doesn't assist Dr. Stevenson in some of his interests, that we are unable to admit, at the present time, narcotic addicts for treatment, unless they have unfortunately had an over-dose of narcotics. In other words, we don't accept them for withdrawals there.

Senator HODGES: Is that because of lack of space, Doctor?

Dr. RANTA: Well, that is partly the problem. Had we the space I suppose we could find the means. But the other problem too is that it is not part of, or within the Hospital Insurance Act to accept them.

Senator HODGES: But the same thing applied before the Hospital Insurance Act came into being.

Dr. RANTA: As a policy.

Senator HODGES: But I mean, it isn't solely Hospital Insurance Act.

Dr. RANTA: That's true. Had we had much more space I suppose we could have arranged to have this done in an experimental program.

Senator HOWDEN: I think that applies pretty much all over Canada.

Dr. RANTA: Right across Canada, I think, that is the general policy. So that I am presenting this, and I think this should be carefully noted by the committee, that this is a personal view and although some of it may jive in with everything the committee has said, Dr. Foulks see eye to eye with the need for research, I felt it necessary to advance some points in case they didn't come before the Committee. I'm presenting this as an individual and community problems.

The solution to the narcotic addiction problem will not be found until we change our attitude towards the narcotic addict. We must differentiate clearly between the narcotic addict with his personal problems and narcotic trafficking with its community problems. We must recognize that narcotic addiction is a medical problem with strong social and psychiatric implications and that narcotic trafficking is an economic problem with strong criminal implications. To plan to deal with them together, by the application of some single "magic" formula, would be fanciful and doomed to the same failure that has rewarded the methods employed in North America.

In discussing the addict's problem, before the Opium and Narcotic Drug Act was revised in 1954, we could argue that the Act was designed to control the legal distribution of narcotic drugs and to satisfy our international commitments in the prevention of illicit trade in narcotics. Official interpreters of the Act have stated that it was no offense to be an addict (except an opium smoker) and that the arrests of addicts were merely incidental to the general program of controlling illicit trade.

However, the 1954 revision of the Act has, by indisputable implication, given authority to the practice of considering addiction an offense. To hide behind the interpretation that possession of narcotics is the "crime" is merely to show our determination to falsify the intention of the law and to deal with the addict as a criminal. We have even carried this to the extent of routinely stopping him in the street and searching him solely because he is known to be an addict.

In considering the intent of the 1954 revision of the Act it is entirely beside the point whether there is any truth to the statement that most addicts are juvenile delinquents or criminals before they become addicts, nor is there any relevance in the statement that most addicts have poor work histories or are socially maladjusted before addiction. Neither of these statements gives us any reason for writing a law which guarantees that an individual with a certain medical disorder will be dealt with as a second-class member of the community.

In the 1954 revision, Section 4 (sub-section 3) is written to control narcotic trafficking. This quite properly increased penalties for trafficking as recommended by the Community Chest's Committee on Narcotics in 1952. But Section 4 (sub-section 1) retains the penalty for possession unchanged. Since the original intent of the law is covered by Section 4 (sub-section 3), that is the section on trafficking, it is obvious that Section 4 (sub-section 1) is now addressed against the addict. Thus, it is mandatory for the Court to sentence an addict found in possession of even an infinitesimally small amount of narcotic drug to a minimum of six months' imprisonment.

We can no longer argue that the law is directed only against illegal trafficking. The recent revision has subtly changed our original intention to correspond with the growing resentment that we have shown towards the addict. We seem to object to his presence in the community mainly because he represents illicit trafficking to us and, as we have been unable to control it, we strike at the victim rather than the perpetrator of the crime. If we carried this concept into other fields, we would see the imprisonment of the robbed as well as the robber.

Moreover, the 1954 revision now contains a feature which is contrary to usual Canadian attitudes. The laws now place the onus of proof upon the addict to prove that he was not in possession of the drug for trafficking purposes. Possibly more than any other feature of this ill-conceived Act, this indicates our determination to look upon the addict as a second-class citizen.

Senator HOWDEN: Is that Dominion?

Dr. RANTA: That is a Dominion Act,—the Opium and Narcotic Drug Act.

Senator HOWDEN: That will have to be changed, right away.

Dr. RANTA: These changes have made the Act, originally intended to control illicit traffic, into a vindictive act against the addict, but the authors of it were apparently unwilling to make their intentions obvious. Thus, as we continue to misunderstand the addict's problem, we do the only thing we know how—we thrust the addict into jail, or we propose to isolate him in an island, or in a concentration camp complete with armed guards and blood hounds.

This is precisely the attitude that we employed up to a century ago in dealing with mentally deranged persons. Fortunately, we began to under-

stand their problems and we ceased being punitive against them. More recently, our attitude towards the alcohol addict has changed and we are beginning to give him assistance rather than social ostracism. We recognize that the alcohol addict, who is actually damaged much more by his addiction than the narcotic addict, should not be deprived of his rights as a citizen merely because he is addicted.

The 1954 revision of the Opium and Narcotic Drug Act appears to have been poorly conceived. It seems to have been a token gesture towards those who are convinced that our present methods, patterned after the practices in United States, have for years been inept, ineffective and unrealistic. A change in direction has long been overdue.

It is strongly urged that the Senate Committee give full consideration to recommending a complete revision of the legal aspects of narcotic control. In this revision the following changes should be given attention.

1. There should be no mandatory sentence for possession, so that the Court may free the addict unless illegal trafficking is clearly indicated.

2. The interpretation of the law should protect the individual who is addicted from being tried or sentenced merely for his addiction, even if in possession.

3. Trafficking should be viewed as a crime worthy of inclusion in the Criminal Code, rather than in a health act.

4. The burden of proof that possession was for the purposes of trafficking should be returned to law enforcement agencies as in the case of other crimes.

5. The medical profession and representatives from the communities most concerned should be invited to form a Commission to assist in the preparation of the new law, especially where it pertains to narcotic addiction.

These changes in the law should be coupled with the development of a comprehensive program to assist the addict who wishes to discontinue the taking of narcotics. It is essential that such assistance should be rendered only to the addict who voluntarily submits to treatment, rehabilitation and follow-up, and there should be no more penalty imposed upon the "back-slider" than upon the alcohol addict who fails to follow through his good intentions.

This is the area that requires our attention in research. We can study narcotic addicts in prisons, as has been done in United States for years, and we shall get no more information that is available from police court records. From research in the prison setting we can expect only a restatement of the attitudes that have led us into the difficulties that we now face.

It is urged that the Senate Committee give consideration to recommending that a Narcotic Institute be established in Vancouver, under the direction of a suitable voluntary health agency and financed by federal and provincial funds, in order to further voluntary treatment, rehabilitation and follow-up of narcotic addicts and to sponsor and conduct research in these areas.

Dealing with the community's problem, we have been attempting to build a narcotic-proof wall around North America, and we have done this in the hope that the narcotic addict would "wither on the vine" as his narcotic supplies are cut off. This could possibly be accomplished if we had adequate manpower and changed our law-enforcement techniques. But it would take something akin to conscription to get enough manpower and the establishment of martial law in order to control the movement of the people of each community.

The prevention of the known narcotic addiction in Vancouver alone would require the daily interception of the delivery of a package of pure heroin not much larger than a cigarette package. To capture a few ready-to-use capsules of diluted heroin out of a possible total of some 5,000 used daily in Vancouver hardly even annoys the problem.

The package of pure heroin represents a profit of \$20,000 or more. On the illegal market it is worth 50 times its weight in gold. While the present situation exists, there will always be men and women ready to engage in its transportation and distribution. Narcotic trafficking is perhaps the only business that guarantees profits of some 4,000 per cent to those willing to take the risk. This enormous profit, of course, comes out of the pockets of every person in the community.

If we are committed to the prevention of narcotic addiction by the use of our present impossible techniques, which have been deplored even by those who must carry them out, then we should pursue the matter vigorously and not in the "token" manner now employed. This would mean an all-out effort, with a resultant disorganization of Canadian life as we know it, in order to bring a temporary solution to a problem presented by 0.03 per cent of the population. Under these circumstances it might even be possible to conceive of the usefulness of a "Devil's Island" for narcotic addicts. But it should be recognized that this would interfere only temporarily with illicit traffic and we would eventually face up to finding a solution which will have a permanent effect upon illicit traffic.

On the other hand, we might admit that our present methods have failed and that the problem is not big enough to warrant disruption of our way of life. In this event, some other technique must be adopted to solve the community's problem. This solution must be based upon two premises:

1. The enormous profits to be made is the only factor that maintains narcotic trafficking in the face of the penalties that can be imposed upon convicted persons.

2. The narcotic addict will continue to be addicted, in jail or out of jail, with narcotics or without narcotics, as long as he has no desire to stop his addiction. This desire to stop cannot be forced upon the addict. It must come from within. The addict with no desire to stop will, even if temporarily restrained, return to narcotics whenever the opportunity presents itself, even if it means invasion into legal sources of supply.

The illicit trade in narcotics can be materially diminished by cutting into the profits of the trade. This could be done by permitting and employing the addict's physician to prescribe narcotics by rescinding Section 16 (sub-section 2) of the 1954 revision of the Opium and Narcotic Drug Act which prohibits the doctor from prescribing drugs to addicts for self-administration. For special cases or those unwilling or unable to attend a private physician, community services should be established where physicians could administer, dispense or prescribe narcotics.

In order to maintain a check on utilization, physicians should be required to make a confidential report on addicts under their care to the Health Department and to refer addicts willing to undertake cure to a treatment and rehabilitation centre, or special cases to the community services. Additional checks should be maintained as at present through regular prescription inspection at pharmaceutical outlets.

It would be miraculous if this procedure would wipe out all illegal handling of drugs, but "organized" illegal traffic could hardly flourish. The chief illegality would undoubtedly revolve around misappropriation of legal supplies, which would be insignificant in effect and should be dealt with to the full extent of the law.

This procedure would assure that the narcotic addict would be treated in a manner similar to any other citizen with a medical problem. If he wishes to live as normal a life as his addiction will permit, he will be able to do so. However, if the addict does a criminal act, the law should deal with him as it would with any other member of the community.

Despite all the claims that have been made that Canadian and British practices are the same, it is particularly in this area that the methods differ. The instructions issued to doctors and dentists by the Home Office in Britain are permissive in character and designed to inform the doctor under what circumstances he is permitted to prescribe free narcotic drugs for his addicted patients. This permission given to the British doctor is obviously valued by British law-enforcement agents, as is evident in a paper recently published in the (November issue, actually) *Medico-Legal Journal*.

If we were to adapt the successful practices of Great Britain to our problems, rather than continue to follow the practices that have proven unsuccessful on this continent, we must recognize that we would not be providing the addict with anything different from what he will continue to provide for himself. Nor should we be concerned with the argument that the doctor in practice should not be called upon to care for the addict by prescribing narcotics. The Canadian doctor does not usually consider that his British colleague is inferior in his ethics, scruples or methods of practice. Moreover, the doctor must constantly provide treatment that has no hope of curing his patient, e.g., insulin for the diabetic and several other preparations which serve to maintain the patient because of some innate or acquired deficiency of the body. Nor should we reject this procedure simply by posing questions to illustrate how complicated this procedure would be to institute in Canada. Nor should we be satisfied to reject the procedure by statements that dispensing of narcotics was tried in United States twenty-five years ago. Times have changed since then. We have lived through the age of Prohibition with its resultant gangland warfare. And nowhere has this procedure been tried to solve the community's (not the addict's) problem in combination with a voluntary treatment and rehabilitation service available for the addict desiring help.

It is recommended that the Senate Committee give genuine consideration to diminishing illegal traffic in narcotics by permitting and employing doctors to treat, administer, dispense and prescribe narcotics for addicts who do not voluntarily wish to avail themselves of treatment and rehabilitation facilities.

Senator HOWDEN: You would propose that as a primary step?

Dr. RANTA: No, I didn't say that. No, I was thinking in terms of combination with all of the other proposals.

Senator HOWDEN: But that obviously would be a primary step.

Dr. RANTA: That would be one of the steps, yes. In combination with the treatment. Without a treatment and rehabilitation service we would be dealing only with the Community problem, and not with the addicts problem at all.

Senator HOWDEN: I see. But that would be a very important point.

Dr. RANTA: Yes, it would be.

In conclusion, the recommendations contained in this statement are made with the knowledge that they appear to condone narcotic addiction. However, we must be realistic enough to recognize that narcotic addiction exists and that it will continue to exist under our present techniques of unsuccessful control and that the damage being done to the community is much greater than the damage done by the addiction to the individuals concerned. We must also recognize that present techniques are permitting and may actually

be encouraging, an increase in narcotic addiction and an extension of it into progressively younger age groups. We are faced with the need for a drastic alteration in the direction that we have been going for many years. The most important alteration that we must make is a change in our attitude towards narcotic addiction so that the addict is given both understanding and assistance whether or not he wish to overcome his addiction. These will not be achieved by continuing to confine the addict to jail, no matter how much we study him while he is there.

Senator HORNER: Very good.

Mr. LIEFF: Doctor, I have no doubt that you are obviously acquainted with the literature on the narcotics clinic?

Dr. RANTA: Oh, yes, I am indeed.

Mr. LIEFF: And you are obviously acquainted with Dr. Stevenson's—

Dr. RANTA: Oh, yes.

Mr. LIEFF: And you have read the literature that everybody else has read.

Dr. RANTA: Oh, yes.

Mr. LIEFF: You're making a distinction in the sort of community service you are talking about.

Dr. RANTA: That is right.

Mr. LIEFF: A community service; we can call it a clinic if we want to. That's just another name for it.

Dr. RANTA: Yes, although there is a difference in that that is secondarily proposed.

Mr. LIEFF: Yes. I was just coming to that. You are making this difference—that in order for a person to have drugs given to him at one of these community centres he would have to be part of the treatment plan and the rehabilitation plan.

Dr. RANTA: Not an actual member of the plan. The rehabilitation plan would—

Mr. LIEFF: He would be one of the patients, that is what I mean.

Dr. RANTA: He would be one of the individuals who doesn't wish to become a member of the voluntary treatment service.

Senator HODGES: Oh, you don't combine—

Dr. RANTA: The basis of treatment and rehabilitation service is based on the voluntary treatment of the addict. I can't conceive of an addict being forced to not become addicted.

Senator HOWDEN: But you do believe that this would commence to eradicate an evil.

Dr. RANTA: As far as the community is concerned. That's my total submission, really, an appeal for a change in attitudes towards the addict and to separate the addicts problem, or the way in which we are thinking of the addict, from what is actually a community problem and the evils that arise out of it. I think there's quite a definite difference between the two, and too long we have attempted to think of them as one problem. We actually are faced with two problems—the community and the addict.

Mr. LIEFF: Well, doctor, you know that the so-called clinics in the United States operated for about four years.

Dr. RANTA: From 1919 to 1923, yes.

Mr. LIEFF: And I suppose you will agree that they were a complete failure. Everybody seems to agree with that.

Dr. RANTA: No. Everybody doesn't agree that they were a complete failure.

Mr. LIEFF: Do you?

Dr. RANTA: No, I don't believe that they were tried long enough and they were tried in a setting which was quite unlike our own.

Mr. LIEFF: Well, I think, perhaps, to make it just a little clearer to the minds of perhaps some of us, and myself at least, in what way do your community services differ from those clinics?

Dr. RANTA: Because the principal difference would be, this would be part of a comprehensive program set up in which you would have the opportunity to assist the addict if he wished to be assisted. That did not exist at the time these clinics were made available. All that was being done there was to deal with the community's problem—that, here you had a group of individuals, what were you going to do with them. Illicit trade was not yet a major problem and it was almost like a "Devil's Island" in the centre of the city, that's all.

Senator HORNER: Was it not a fact that they were allowed to carry away—carry it with them.

Dr. RANTA: Yes. Just the same way they do in Britain.

I'm going to quote from Dr. Stevenson's very fine paper in which, incidentally, we don't see eye to eye on these things, and we're still friends on it. But the reason why I point it out, that this is permissive legislation and this comes from the instructions in the Home Office, in that it described—I'm on page 8, in which Dr. Severson quotes from page 10, section 51, Morphine or Heroin may properly be administered to addicts under the following circumstances; (And that sounds like permissive legislation) namely:

A. Where patients are under treatment by gradual withdrawal method with a view to cure.

B. Where it has been demonstrated after prolonged attempt at cure (and that cure is by the withdrawal treatment) that the use of the drug cannot be safely discontinued entirely on account of the severity of the withdrawal symptoms produced and,

C. Where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life, when a certain minimum amount—minimum dose is regularly administered he becomes incapable of this when the drug is entirely discontinued.

Mr. LIEFF: Just while we are at that. You talk about the patient "while capable of leading a useful and relatively normal life", would you make it part of the deal that he would have to be gainfully employed in some useful occupation before he could get anything from your community service.

Dr. RANTA: This doesn't say that. This says "while capable of" and I think capability is the important thing.

Mr. LIEFF: Supposing he just won't work, he won't do anything, would you still give him the drugs.

Dr. RANTA: I think that's one of the points that would have to be decided by the group that was concerned with them. I think that, for us to answer all of the questions, would be to have us pose as experts in the field. And I'm not posing as an expert in the treatment of narcotic addicts in any particular way, because I don't think there's anybody here or in Britain because I think Dr. Richmond pointed out a very important thing, that his experience with narcotic addicts (when he was speaking this morning) is nil, in Britain,—it's only here that he's had his experience. And when you consider the 60,000 doctors that there are in Great Britain, and there are only three or four hundred addicts, there aren't very many addicts to go around to give doctors any experience even to become expert—

The CHAIRMAN: What drug do they use, doctor?

Dr. RANTA: They use morphine and heroin.

The CHAIRMAN: Yes, but what drug are they using in Great Britain, of the drug addicts of 305? I'll tell you why I'm asking. There was a time when many countries could have pointed their finger here. We had an open season for opium. There was a time I remember in the municipality where I live, we licensed the Chinese to smoke opium. Now there are countries who could have pointed to British Columbia, Canada, and say, they allowed opium smoking and it got out of hand. They might not be using opium. Now they're using heroin in the United States.

Now, I'm not one to be easily convinced that it's the proper thing to throw Great Britain in our faces and say they're successful, if they're not using heroin.

Dr. RANTA: They are using heroin.

The CHAIRMAN: Entirely?

Dr. RANTA: Not entirely, no. Because some of them even prefer morphine and it's given them. There are some addicts that have used combinations of drugs—some prefer barbiturates along with their morphine.

The CHAIRMAN: It's not only the make up of the people but it's the kind of drug they have.

Dr. RANTA: They are certainly using heroin. This instruction from the Home Office as a memorandum as to duties of doctors attending says "Morphine or heroin may properly be administered to addicts in the following circumstances." So that either drug can be used.

Senator HODGES: I think another thing we have to take into consideration when comparing Great Britain with this Country is that those members of the Senate Committee who were there when the Honourable Paul Martin spoke, he pointed out that their records are kept in a different way from ours. They don't have records from the wholesalers and druggists.

The CHAIRMAN: You have sold the idea to the people and we have got to meet this head-on. You have made it appear that if we hold a standard over our system to the British system it would all end. That's the viewpoint I get from people due to the information you sent out in your pamphlet. And you come again, right today, and we have got to adopt the successful practices of Great Britain to a Province.

Dr. RANTA: No, this is, as far as the information that we have been able to gather and—

The CHAIRMAN: You sent a man across there to find out.

Dr. RANTA: There were members of our Committee who had actually worked in Britain. Now, there again, they hadn't had a great deal of experience because a great deal of experience is not available in Great Britain,—

Mr. LIEFF: As a matter of fact, doctor, they just don't have a problem there.

Dr. RANTA: Well, they consider that their three or four hundred people are problems because they have addict problems.

Mr. LIEFF: But we have a problem that you've gotten down in decimal points to 0.03. Where would their points go to .00007—

Dr. RANTA: That is right.

Mr. LIEFF: Do you know anything about the marijuana problem there?

Dr. RANTA: No, I don't. There have been reports—Inspector Lysle's report in the November issue entitled "Dangerous Drugs in London" presents a pretty good comparison of their problem with marijuana. They don't have much of a marijuana problem either.

Senator HOWDEN: Marijuana isn't comparable to morphine. It's not the same kind at all.

The CHAIRMAN: That's the point I was raising. If there are a great number of marijuana users in Britain, it is unfair then to quote it against the great users of heroin.

Dr. RANTA: There aren't great numbers of marijuana users.

The CHAIRMAN: We'll find out officially before we accept that statement of yours.

Dr. RANTA: That's right.

Senator LEGER: Doctor, you suggested in your brief that a doctor could prescribe heroin. Do you believe that they could prescribe?

Dr. RANTA: Yes.

Senator LEGER: And give it to the patient himself?

Dr. RANTA: Yes. That is what is done in Britain with their addicts.

Senator LEGER: Wouldn't it be better for the doctor to administer it instead of giving it away?

Dr. RANTA: It would be better but it would be an economically difficult problem. First of all, it would absolutely interfere with the life of the addict and it would certainly interfere with the life of the doctor who would have to see his patient four times a day.

Senator LEGER: How many pills would you give in a day?

Dr. RANTA: I think that's a detail that would have to be worked out if this were considered at all. I feel that any handling, for example, individuals who require morphine for medical illness we usually supply them with a week's supply.

Mr. LIEFF: Doctor, just one more question. We're not putting you on the defensive, we just want to get information, that's all. You're giving the addict an opportunity for treatment.

Dr. RANTA: Yes.

Mr. LIEFF: He doesn't choose to get treatment.

Dr. RANTA: Yes.

Mr. LIEFF: Is that right?

Dr. RANTA: Yes.

Mr. LIEFF: And we have an addict who doesn't want your treatment. So you're going to give him drugs in your clinic.

Dr. RANTA: Yes. Well, he's going to get it illegally anyhow.

Mr. LIEFF: Yes, but you're going to give him drugs, if he doesn't want to get the treatment, you're still going to give him drugs.

Dr. RANTA: Yes.

Senator HODGES: That is one point I wanted to ask. I see you say it is recommended that the Senate Committee give genuine consideration to diminish illegal traffic in narcotics by permitting and employing doctors to treat, administer, and so and so,—for addicts who do not voluntarily wish to avail themselves of treatment and rehabilitation facilities.

Dr. RANTA: Yes.

Senator HODGES: It seems to me that you're not encouraging the addict to undertake treatment and rehabilitation.

Dr. RANTA: Your doctor's problem will be to encourage the treatment and rehabilitation of the patient. We can't get to them and hammer it into their heads. We have to deal with them until such time as, in much the same way as the alcoholic is handled, you'd have to deal with them until you persuade them that this is the thing to do.

Senator HODGES: The only thing is, Doctor, another point I want to mention in connection with this, don't you think this is likely to lead to abuse among the medical profession?

Senator HOWDEN: I don't understand—

Dr. RANTA: I don't think it would lead to any greater abuse than, perhaps, might even exist at the moment.

Senator STAMBAUGH: Were you here under the prohibition days when the doctors were prescribing at two dollars a crack?

Dr. RANTA: Yes, I know about that.

Senator STAMBAUGH: Some of them prescribed one thousand a month—prescriptions.

Dr. RANTA: That was a ridiculous situation, wasn't it?

Senator STAMBAUGH: Won't they do this with narcotics?

Senator HODGES: With greater profits to be made?

Dr. RANTA: Well, within the control measures that might be set up, the doctor would not be free to give narcotics to anyone—

Senator HODGES: We thought that about prohibition.

Dr. RANTA: No.

Senator HORNER: You would have them registered?

Dr. RANTA: He would at least send a confidential report to the health department. The only legal channels he would have for the dispensing of it would be through the regular pharmaceutical outlets and those now, as I well know, are viewed very carefully by the narcotic inspector, and you account for every single quarter grain that is used even in an institution the size of ours.

Senator HODGES: Quite, but that quarter grain might easily be diluted or adulterated by unscrupulous doctors, and without casting any reflection on the Medical profession, I mean, one knows that there are some unscrupulous doctors.

Dr. RANTA: We always try to think there are relatively few of them and I think that in time those would be picked up as well as any other individual who goes into what would then be illicit traffic.

Senator HOWDEN: Dr. Ranta, I gather that your submission contemplates the establishment, first of all, the registration of addicts so that you will know that an addict is entitled to service.

Dr. RANTA: Yes.

Senator HOWDEN: Because he will bring his registration card along or some means will be found by which you will know he is a registered addict. And only registered addicts will obtain morphine.

Dr. RANTA: Yes.

Senator HOWDEN: And then you do contemplate, no doubt, in the future, some near future, that there will be dispensaries, if you like, at which places these addicts will have to come to get their hypodermic injections.

Dr. RANTA: My idea of that was that these would deal with special cases, particularly. Often the individual doctor might not be able to deal satisfactorily with an addict. Under those circumstances he could refer him to a special centre, which might, under those circumstances decide that it must administer rather than dispense.

Senator HOWDEN: That is the only way I could see it. And I would expect that, doctor, to be paid by the government—

Dr. RANTA: That is what I am—

Senator HOWDEN: —for nothing else but giving hypodermics of morphine, and I would expect him, when and if—if and when—the opportunity occurred to reduce the dose a little bit just to see what effect it would have,—

Dr. RANTA: Or even continue on with the educational program as far as the addict is concerned so that eventually that addict can be lead into the rehabilitation service.

Senator HOWDEN: It all would have a tendency that way.

Dr. RANTA: Yes.

Senator HOWDEN: I would be inclined to go for that suggestion myself if the addicts were registered, definitely registered and if that work was given by a medical man that was paid, because there would be no temptation for him to alter dosage or anything of the kind.

Dr. RANTA: That is why I used the word "employed" throughout this, that the physician be permitted and employed.

The CHAIRMAN: Doctor, what have you to say about the U.S. system. No doubt you have studied that as well as Britain?

Dr. RANTA: Well, I think they are in exactly the same problem as we are in. I don't know any more reason why they are in it than I know why Canada is in it—

The CHAIRMAN: It is given out that many of them are failures, parts of the systems that have been tried. We should have that experience too.

Dr. RANTA: You mean as far as the prohibition is concerned? We have that. We have the prohibition—

The CHAIRMAN: And as far as getting, under medical attention, drugs?

Dr. RANTA: They don't have that.

The CHAIRMAN: Didn't they try it out in the States?

Dr. RANTA: They tried it, yes, for a three year period—

The CHAIRMAN: And it didn't work out, it was a failure.

Senator STAMBAUGH: Are you opposed to any form of compulsion with regard to looking after the—

Dr. RANTA: Yes, I am. If we are dealing with the addicts problem. Now, if we decide that we are going to go all out and just deal with the community problem, then we can do it in several ways. We can take the suggestion that has been made and put them all on an island, and then we'll, maybe in a little while, have to have a second island to deal with the group that grows up, because illicit traffic will still have an opportunity of growing up.

Senator STAMBAUGH: You would leave it to the individual doctor to prescribe the amount of dose that an addict should have?

Dr. RANTA: Yes, I would.

Senator STAMBAUGH: And would you make it so that doctor couldn't increase the dosage?

Dr. RANTA: Increase the dosage? No, I think that would be a medical problem—that he would have to be able to adjust the dosage according to the needs of his patient. It may actually have to be increased on some occasions, and then on other occasions he may be able to decrease it. And certainly, his objective, all the time, would be to cure the addict of his addiction.

Senator STAMBAUGH: These addicts that refuse any help, or at least they don't want to get rid of it, they would be trying to increase their dosage, I presume.

Dr. RANTA: Up to their needs they probably would be trying to. But the point is, there, that you would be dealing with them from the point of view of the community problem. You would then be preventing them from becoming a centre or the goal of the illicit traffic that is present in the community.

Senator STAMBAUGH: You would leave it up to the doctor to be the judge as to the amount of the dose and whom he should give it to?

Dr. RANTA: We do that with every other drug.

Mr. LIEFF: Supposing the patient isn't happy about that. He will just go back to the street, won't he?

Dr. RANTA: A few of them might, yes. But I don't think we should take the situation as they did in the United States, if you read the literature—

Mr. LIEFF: I am sure you are acquainted with Dr. Stevenson's objections?

Dr. RANTA: Oh, yes, I am, and I don't agree with them all, as Dr. Stevenson knows.

Mr. LIEFF: Could I get back to the employable addict? He doesn't want the treatment and he won't work. I think you said that is a detail we would have to work out?

Mr. LIEFF: What is your own opinion about it?

Dr. RANTA: My own opinion is that we would have to carry him along, even to the point of providing him with social assistance, even if we had to feed him.

Mr. LIEFF: Thank you very much.

Senator HORNER: At the present time he might be refusing to work, but you would at least, under your plan, take the incentive away from the boot-legger and the illicit trafficker. That is one thing you would accomplish even if you didn't put him to work.

Dr. RANTA: That is right. And you would be reducing under those circumstances, the cost, as far as the community is concerned.

Senator HORNER: Yes, the cost to the community.

Senator STAMBAUGH: You would have to give him all he wanted if you took him away from the illicit trade.

Dr. RANTA: The point is, what is all he wants?

Senator KING: All he needs.

Senator STAMBAUGH: Whenever he feels he wants a thrill, I suppose, he'd want medicine—

Dr. RANTA: There are very few of the long-term addicts that I have run into (and I am sure that Dr. Stevenson would probably substantiate this) that the amount of thrill that they get from it, the kick that they get from it, is very slight, if anything.

Senator STAMBAUGH: Isn't it usual among addicts though to increase the number of doses they take from year to year. They generally grow—

Dr. RANTA: Yes, and sometimes they decrease the dosage.

Senator STAMBAUGH: Of their own accord?

Dr. RANTA: Yes.

Senator STAMBAUGH: That's seldom though, isn't it?

Dr. RANTA: I don't know that anyone has enough experience on that. But certainly, from the point of view of addicts, they don't have a constantly increasing amount. It may actually fluctuate, for all we know, according to the stresses that they're under at the time. I think it's a very interesting point—I notice there's a copy up here—Dr. Howe's recent article in the New York State Medical Journal of Medicine, that the attitudes as developed in the United States, even in defining the addict, are quite different than those held in Britain. In this, there is Doctor Vogel's definition in which he defines addiction as an individual's use of drugs to such an extent that the individual or society is harmed.

Senator HOWDEN: Who is to be the judge?

Dr. RANTA: This is a very crucial definition and difference between the attitude on this Continent, the attitude that we have, and the attitude that they have in Britain. Dr. Dent, who has been editor for over a decade of the British Journal of Addiction, states in his definition that an addict is one who cannot be normal without a drug.

Senator HODGES: Don't you think that their definitions might be colored by the fact that they haven't the size of the problem we have here.

Dr. RANTA: Oh, yes, but most of Dr. Dent's association has been in the alcoholism field and he is speaking in terms of all addicts, not narcotics alone, even tobacco addicts.

Senator HOWDEN: I think that is the best definition; it's pretty close, it pretty nearly hits the nail on the head.

The CHAIRMAN: Could you tell us Doctor, if this social problem with addicts in Great Britain is similar to the social problem we have.

Dr. RANTA: Certainly some addicts have their own personal social problems, but certainly they do not have in Britain the same type of difficulty as we have. They don't understand (the men whom I have spoken to who have come over here) they don't understand our term "criminal" addict. You have to explain to them what you mean when you say "criminal" addict.

The CHAIRMAN: They haven't examined any of ours, have they, to find out the difference between the British addict and ours. There must be some difference.

Dr. RANTA: Well, I don't know. That's something that will require a lot of study.

The CHAIRMAN: Whether it's the makeup of the people or whether it's the kind of drug I don't know. But they have no problem at all with forty-five million people—they have no problem.

Mr. LIEFF: Isn't it a fact that the English criminal just doesn't use drugs? Surely they've got more than three hundred criminals in forty-five million people!

Dr. RANTA: Maybe if we look at it this way, that the English narcotic addict has never been put in jail and therefore he isn't a criminal, that is perfectly obvious, I think.

Mr. LIEFF: I just want to ask you one other thing. Dealing with the matter of definitions, the people interested in the problem for some years have been trying to arrive at an acceptable definition and that, in itself, has been quite a study, has it not?

Dr. RANTA: That is right.

Mr. LIEFF: We haven't arrived at one yet, have we?

Dr. RANTA: No, I was quoting two individuals who are considered to be leading authorities, one in the United States and one in Britain. I don't think that anybody would say that—

Senator HOWDEN: What was that first definition again, please?

Dr. RANTA: It says here one of our distinguished authorities defines addiction as "a condition where the individual uses a drug to an extent that the individual or society is harmed". In other words, it is a harmful influence.

Senator HOWDEN: The difficulty with that definition is, who is to be the judge. I think the other definition is a very much sounder definition.

Dr. RANTA: It has been developed out of a community that, in my personal opinion, has a sounder approach.

Senator HOWDEN: Yes, exactly.

Mr. LIEFF: Do you know the World Health Organization's definition?

Dr. RANTA: I don't off hand. It is a lengthy one.

Mr. LIEFF: Perhaps we might get it and put it on the table here some time during the week.

Dr. RANTA: Yes, I can't quote it.

Mr. LIEFF: Yes, thank you.

Senator HOWDEN: Just quote that second definition, for the moment, please.

Dr. RANTA: The second definition, as it reads here, Dr. J. Yerbury Dent, Editor of the British Journal of Addiction, states, "an addict is one who cannot be normal without a drug".

Senator HOWDEN: Hear, hear. That is it. That has got it.

Senator GERSHAW: Mr. Chairman, on page 4, it seems to be implied there that, it seems to be made so that the drug could be given for self-administration. Is it not a fact, in your experience, that self-administration is generally a poor method?

Dr. RANTA: Well, it all depends, again, on the matter of the individual too. We do have individuals that are medical addicts and they have cancer, or a disease which produces fairly intractable pain. With those individuals who have become addicted some weeks go by and everything is fine, and another week goes by and it isn't because they themselves will complain that they had more pain or anything like that, it is just that they are more aware of pain, let's say, and under those circumstances their week's supply would only last four days.

I think, we don't know enough about humans to say just exactly how they are going to react, and I couldn't make a general statement on whether self-administration would be the wrong thing or the right thing. We're dealing with this from the point of view of the community problem—how to solve the community problem. This is something that you couldn't practically set it up on the basis that every dose of every addict would have to be administered by someone else. If that were so, there would be, let us say, fifteen hundred addicts attending clinics in Vancouver, roughly on an average of four times a day and some of them would be there six or seven times a day. It just would not be a practical thing, and you must base it on being a medical problem, treated by the individual doctor.

Senator HOWDEN: I do believe that the psychiatrist's program now is, in treating addicts, to give them their treatment four times daily, four hours between, to go from ten to two and two to six, and six to ten and keep on going like that.

Dr. RANTA: We have several addicts under treatment in which they have received drugs only twice a day.

Senator HOWDEN: I appreciate that, but most addicts want a drug every four hours, six times a day, or every six hours, four times a day, I think that's the way—every six hours.

Dr. RANTA: Yes. It roughly averages out to somewhere around four doses a day.

The CHAIRMAN: Any other questions, honourable Senators? If not, may Senator HOWDEN: Yes.

I thank you, Doctor Ranta.

Our final witness this afternoon is Reverend Dr. J. Hobden of the John Howard Society.

Reverend Dr. Hobden, will you please come forward.

On behalf of the Committee, I welcome you Reverend Hobden.

Rev. Dr. HOBDEN: Mr. Chairman, Honourable Senator Reid and Honourable Senators of this Committee.

I have been requested to make this submission to you on behalf of the Board of Directors and members of the Staff of the John Howard Society of British Columbia, which is an agency in the Community Chest and Council, of the City of Vancouver.

Qualifications

Our Society, named after the illustrious John Howard, Britain's great 18th century prison reformer, has been serving in the Prison Reform and Prisoners' Aid and Welfare field continuously here since 1931. Vancouver has been our base of operations both on account of its large district population, and also because of its contiguity to the Canadian Penitentiary at New Westminister, and the largest British Columbia Provincial Prison of Oakalla in Burnaby. We have the honour to be the first John Howard Society to be organized in Canada, and it has been my privilege to serve in my present capacity since the commencement of our work. Our purpose is two-fold, first, the educational and promotional service of Prison Reform, and, second, that of Prison Visitation coupled with follow-up service in the after-care or post-prison period. We introduced the pattern of Case-Work Service into the post-prison area with the employment of trained social workers for this purpose. This has now been adopted by all the John Howard Societies which operate in Canada from Victoria, B.C., to St. John's, Newfoundland, and number nearly 30 societies. Our own staff at the moment numbers five social workers, one being a woman who is in charge of our women's and family division, and two office workers. Our caseworkers are also burdened with heavy case loads because of the increasing demands on their services, particularly as their objective is full rehabilitation for those of our clients who are willing to co-operate with us for their own good.

Our Board feels that we can best serve your Senate Committee by presenting to you some of the results of our experience in our 24 years of service in this field, particularly as we have been thrown in very close contact with the problem in which you are now interested, through serving many of those who have been released from prison and penitentiary for offences under the Opium and Narcotic Drug Act.

Commendations

We would refer to the great services rendered by the Royal Canadian Mounted Police, and the Vancouver City Police Department through their respective narcotic sections and commend them for their work of detection and law enforcement in this regard. The illicit traffic in narcotics in Canada is a vicious criminal movement, promoted for personal and selfish gain, without any regard whatsoever for the bodies and souls of its victims. The chief promoters, who usually remain far enough in the background to avoid any evidence of actual unlawful distribution are among the worst enemies of the State, and are foes of Law and Order and Decency. They deserve little pity when apprehended for their wrong doing. We feel very differently concerning the many victims of the traffickers' lawlessness.

A word of commendation is likewise due the Vancouver Community Chest and Council for its study and report prepared by its committee of the Health and Auxiliary Division by a special committee on the Narcotic Problem a couple of years ago. Most of its recommendations were acceptable to and welcomed by our community. However, its recommendation of so-called "Narcotic Clinics" (I am sure Dr. Stevenson would feel I should say "Narcotic Dispensaries") to supply registered narcotic users with minimum dosages, we

understand from some members of that committee, was not an unanimous recommendation by all the committee. Our Agency strongly agrees with the minority opinion which is opposed to the establishment of such "dispensaries".

Mr. Chairman, I was very interested to hear Dr. Foulks' reference to that report of the Community Chest and Council in reference to the "narcotic dispensary" suggestion, because upon the publication of that report the hopes of the criminal narcotic group, I can tell you, raised considerably, and they expected an almost immediate establishment of a free dispensary centre. They were in favour of it.

The CHAIRMAN: They were all in favour of it.

Rev. Dr. HOBDEN: Surely. The painful experience of other countries which have so experimented cannot be ignored. The "Bulletin" of the World Health Organization of the United Nations, Volume XII—No. 14, released from Geneva on "The Treatment of Drug Addicts" refers to the legalizing of the supplying of narcotic drugs to the so-called incurable addicts, through the various Medical so-called "Clinics" in the United States—I understand it was five years, not three, from 1918 to 1923 in certain centres. The system failed miserably, it was greatly abused and cures were not effected. I quote again from the document: "In every place where this was tried, this system failed utterly to reduce addiction; on the contrary, it increased and spread to such an extent that the Federal Government was compelled to close all such clinics. Some forty-four of them, operating in various parts of the United States, were closed by the year 1923; thus terminated this very unfortunate experiment".

Apart from the possible abuses of such a system we feel that this approach is not constructive in principle neither is it curative in effect, and if adopted would only keep individuals in perpetual bondage to a soul-destroying habit, and vicious and lawless traffickers would still devise ways of perpetuating their business.

We feel also that we are under obligation to Dr. G. H. Stevenson and his associates who are presently engaged in an important valuable research project on drug addiction in this area, under the auspices of the National Department of Health and Welfare, and in co-operation with the Medical School of the University of British Columbia. Already Dr. Stevenson's studies have been productive of most valuable findings, and when his project has been completed his data will greatly aid governmental authorities in finalizing remedial measures for the addict, and we hope close any gaps which now permit the illegal traffickers to exist.

The John Howard Society and the Local Situation:

Honourable Senators, we know that you have already been informed by the Honourable, the Minister of Health and Welfare, Mr. Paul Martin, of the fact that the addicted in Canada approximates a grand total of 3,213. These are divided as Medical addicts 515, addicts in the professions 333, with criminal addicts numbering 2,364, no less than 1,101 of the latter being in British Columbia. Perhaps Dr. Stevenson would disagree with those figures. I think he thinks our local group number more than that. Our Province also has the unenviable record, we are reliably informed, of having 65% of the total convictions under the Opium and Narcotic Drug Act, in Canada.

Engaged as our workers are, our Agency knows only too well the gravity of the problem confronting us, particularly here at the Pacific Coast. Throughout the entire 24 years of the life of our Society we have been in touch with many members of the convicted addict group, some of whom still turn to us for encouragement and support in attempts at recovery, in spite of repeated failures. Some of these have come to grips with their own personality weaknesses, out of which their narcotic addiction has grown. We feel that addiction is chiefly the result of such basic personality defects.

It is our opinion that addiction serves two general purposes for the criminal addicts. Firstly, it provides a state of personal well-being under the influence of the narcotic which is a substitute for, and an escape from, normal social experience in which the addict feels so much a failure. Secondly, because it is unacceptable to our society, it serves as another technique for giving vent to the uncontrolled, and frequently unconscious, pressure to violate the laws of society which generally characterizes the delinquent. In short, the criminal addict is drawn to addiction not only because of the pleasure-giving effects of the drug, but also because it is, like the other crimes he has committed, an attack on the laws of society. Addiction, then, for the criminal is merely on symptom of a state of criminality or uncontrolled anti-socialness. It is for this reason that we are inclined to doubt that there can be any resolution of the problem of criminal addiction either by the legalized sale of narcotics or by the treatment of addicts solely for their addiction.

With respect to legalized sales we submit that a criminal will not cease giving vent to his antagonism to legal authority merely because one of his techniques is made acceptable to that authority. This fact, as we have mentioned, has been amply demonstrated in the American centres which have authorized legal sale.

With respect to treatment for addiction, we do not believe the community should be asked to underwrite an expensive resource which will cure the addiction habit of the criminal addict but will leave the criminal personality. Nor could we endorse as a hopeful approach to the problem of delinquency any plan which required that a criminal, in order to qualify for very special treatment facilities would be obliged to take the further step of becoming an addict. Only if it could be demonstrated that addiction can be a step in the direction of rehabilitation could such a set-up be acceptable and we have not as yet heard such a claim reasonably defended.

During the course of our work we have met with two types of convicted addicts:

1. Those who have the desire to be free from their addiction, and are determined to make a sincere effort in this direction, and are willing to co-operate with our workers, and,

2. Those (the other group) who prefer to continue in this mode of life and behaviour. Some of these, even when they have been imprisoned for a prolonged period and experienced enforced abstinence from narcotics, admit they have not suffered in consequence of their abstinence. Yet they definitely plan to take a "fix" at the earliest possible opportunity, even planning for this in their own thinking some time before their sentence expires. They have not the slightest desire to be freed of their habit. Such are mostly unstable individuals with personality weaknesses which are responsible for their pre-addiction delinquency. They live in hope of the day of free legalized narcotic distribution. In this connection we should state that it has been our experience that practically all the so-called "criminal addicts" that we have met have been guilty of delinquent behaviour and had associated with delinquent or criminal companions, before they themselves became addicted to narcotics.

We have found that it is most unwise for an addicted person to be encouraged to think of himself as a sick person. This we have found to be fatal to normal recovery. It tends to develop a desire to exploit his own weakness and encourages a permanent mental invalidism. The fact is that criminal addicts are morally sick. They need a real awakening experience. They need to be encouraged to realize their possibilities as divinely created human beings and need also a strengthening or developing of moral fortitude. They need a very different "shot-in-the-arm" from that which they have been

used to, one that will quicken morale, and release motivation to fight a victorious battle by an assertion of their full manhood. Too much sympathy can give dangerous support to a sense of dependency which in time becomes impossible to shake off.

Prolonged addiction may or may not produce permanent injuries to the bodily organisms. Yet, of this we are sure from our observations, it does detrimentally affect the addict's usefulness as a worker, and certainly his dependability and general attitude to life. The heroin addict admits that he has to take several "fixes" each day. The effect is one of lassitude and a lack of real interest in the things of the moment. For these and other reasons—this is very important, Mr. Chairman,—for these and other reasons, many employment agencies hiring men for large industrial firms absolutely refuse to employ narcotic addicts. The loss of productivity and the accident risks are too great.

Yet we know that some addicts can be cured; if they have a sustained will, there is always a way. A case in point is that of one distributor-addict with a record of both penitentiary and prison terms who informed us that as a result of some serious thinking during this last penitentiary term he had concluded that the only way to beat the narcotic habit and to live as a normal human being was just to keep away from that needle. And he used a word I think I should be permitted to use, Mr. Chairman, it starts with a "d" and ends with an "n". Keep away from that d - - needle, now that his incarceration had resulted in his physical cure. He turned to us knowing that the resources of our Society were available to him provided he gave us his full co-operation as we sought to aid him regain his own self-respect and strengthen his resolves. We hope he is now well on the way to achieve complete recovery. The approach of our Agency has always been along this constructive line. In the last analysis there should be hope even for the worst, providing proper facilities, including medico-psychological and psychiatric treatment programs are available in institutions, with a long period of authoritatively imposed follow-up supervision by experienced and competent workers. In this regard the Honourable Senators will be interested to know that the Canadian Remission Service, with which I served for five and a half years as its Western Representative (until a year ago) has for the past two years officially adopted the policy of referring individuals who have been granted a parole under a ticket-of-leave licence from both penitentiaries and prisons to certain social agencies, particularly the John Howard Society of British Columbia, under this plan, in 1954, had referred to it for supervision by the Director of Remission Service, Ottawa, 58 parolees. Thirty were ex-penitentiary inmates and 28 were from prisons. In all, our workers gave no less than 223 months supervision to these "clients". A pleasing feature was that in no case was any cancellation of parole deemed necessary, and every parolee completing his term of parole here in 1954 was successful. As a result of this experience in this area we are strongly of the opinion that these released to parole supervision make the best prospects for full recovery. It might be stated however that the present policy of the Remission Service is not to grant parole consideration to any inmates convicted under the Opium and Narcotic Drug Act, except in unusual clement circumstances.

Recommendations

Our recommendations are based on the needs as we see them from our past experiences, and relate to prevention, reducing the illicit drug traffic to a minimum, securing the best interests of the addict, and the protection of the community.

1. There is urgent need for a central Treatment and Rehabilitation Centre to be established in British Columbia, and in other areas in Canada according to regional needs, with legal authority for the committal and detention of addicts for such period as is necessary for their treatment, as a pre-requisite for rehabilitation. Such a treatment program must not only consider the subject as a narcotic addict, but as one basically possessing personality defects and needing the aid of medico-sociological resources to fill the gaps in his personality equipment. The American institution at Lexington, Kentucky, could show the way.

2. That legal and judicial provisions be made—probably by amendments to the Opium and Narcotic Drug Act.

A. For addict first-offenders charged with "Drugs in Possession" to be committed for a lengthy period of probation and supervision under experienced probation officers who have access to authoritative medico-sociological resources in the community; with periodic reporting to police authorities by the supervisor on behalf of the client.

B. For repeaters, similarly, provisions for forced committal to a lengthy period of Treatment Centre incarceration, to be followed by a lengthy period of after-care and follow-up supervision by qualified Social Workers, or Social Work Agencies such as our John Howard Societies, on the basis of a ticket-of-leave licence and release on conditional parole, including periodic reporting to police authorities on behalf of the client by the supervisor.

C. For the incorrigible addict (say after two committals) to be sentenced under provisions comparable to the Habitual Criminal Section of the Criminal Code of Canada in a segregated facility.

D. Maximum penalties for traffickers and distributors engaged in any illicit and illegal drug traffic, as these will resort to any and every device to perpetuate this whole demoralizing business.

3. That research activities, particularly that now being directed by Dr. G. H. Stevenson in Vancouver be continued indefinitely, supported by the Federal Minister of Health and Welfare.

4. That a National program of youth and adult education on the dangers of narcotic addiction be instituted and launched through the Federal Ministry of National Health and Welfare.

Respectfully submitted, on behalf of the John Howard Society of British Columbia, and signed by myself.

Might I add this word in closing, Mr. Chairman, that this submission is based, not on any wishful thinking, not on any undue optimism, humanitarianism, but is based on the actual real experiences of our Agency that has served in this post-prison rehabilitation field in this area of British Columbia for the past twenty-four years.

The CHAIRMAN: Any questions you would like to ask, honourable Senators?

Senator HODGES: I would just like to ask Dr. Hobden one question. Has all your experience been with criminal addicts?

Rev. Dr. HOBDEN: Yes, it has Senator Hodges. Not the professional and medical addicts.

Senator HODGES: Or addicts who have not been—

Rev. Dr. HOBDEN: No, ours have all been delinquent criminal addicts.

Senator BEAUBIEN: What is the difference between a "medical" addict and a "criminal" addict? I would like to get that clear in my mind.

Rev. Dr. HOBDEN: As far as I can understand, perhaps some of the medical gentlemen could answer that much more clearly, Senator, but I understand a "medical" addict is one who is under medical care and as such is in receipt of such medication by his physician. The "professional" addict would be doctors, nurses or other professional people who have become addicted.

Senator BEAUBIEN: Would a man have to be convicted for a certain offence in order to become a "criminal" addict? Would he be convicted of certain offences of carrying narcotics, or something like that?

Rev. Dr. HOBDEN: The group we call the "criminal" addicts, oh, yes, any who have been sentenced under the—

Senator BEAUBIEN: Wait a minute,—any who have been delinquent prior to becoming addicted. Because, a great number, you know, of our young people have quite likely juvenile court records, including a great number of criminal offences that are not recorded against them (not officially) but the "criminal" addict would be one who has committed criminal offences and who has gravitated to the group of narcotic addicts and who, in turn, has presumably served a term under the Opium and Narcotic Drug Act.

Senator HODGES: In your experience, Mr. Hobden, do you find many addicts have become addicts because of association with other addicts in the penitentiaries and prison?

Rev. Dr. HOBDEN: I wouldn't say too much on that, although there is great danger, one that we have to watch.

Senator HODGES: Yes, I wondered if you had had much experience in that connection.

Rev. Dr. HOBDEN: We have had experience of addicts—

Senator HODGES: The statement is so often made.

Rev. Dr. HOBDEN: Well, we have had experience of addicts who have acquired addiction in Provincial prison. I have never heard of anyone acquiring the habit in a penitentiary.

Senator STAMBAUGH: Is the percentage in your opinion very large on that score. Of those who have become addicts after they had been sentenced to jail—in the Provincial jail.

Rev. Dr. HOBDEN: No, I would't say that, but a great number become addicts after they have served their term and continued the associations that they made in jail.

Senator HODGES: Oh, yes.

Rev. Dr. HOBDEN: A great number of them there.

The CHAIRMAN: Thank you very much, Reverend Hobden.

Ladies and gentlemen, honourable Senators, you all have a copy of the program for tomorrow?

Concurrence.

The Committee adjourned until Wednesday, April 20, 1955, at 10:00 a.m.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

VANCOUVER, B.C., Wednesday, April 20, 1955.

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 10:00 a.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable Senators and gentlemen. It is now ten o'clock if you don't mind we will commence our proceedings this morning.

The first witness before us is Dr. A. W. Bagnall, representing the B.C. Medical Association.

Doctor Bagnall, will you kindly come forward. On behalf of the Committee, Doctor, I welcome you before us.

Senator HODGES: Has the doctor copies of his brief?

Dr. BAGNALL: I'm sorry—

Senator HODGES: It is all right, doctor, I was just asking if you had copies of your brief.

Dr. BAGNALL: Mr. Chairman, honourable Senators, I want to present a brief on behalf of the British Columbia Division of the Canadian Medical Association.

In discussing this matter in advance, we decided that from a purely narcotic addiction angle there was already enough expert evidence being given before this committee. However, we thought perhaps it might be advisable to make some remarks about the legitimate use of narcotics and that is the reason for this brief.

1. We of the medical profession are well satisfied with the present laws and statutes governing the use in Canada of narcotics for the treatment of human disease.

2. While certain regulations necessitate the writing in detail of prescriptions, we fail to see how control of narcotic distribution for the relief of pain in human beings could be otherwise achieved without contributing to an undesirable increase in addiction.

3. There is no indication that the recent slight relaxation in regulations (that is, permitting telephone prescription of narcotics for oral use in mixtures that no narcotic addict could take by injection), has, or will, contribute to narcotic addiction.

4. It is our firm belief that practically no addiction to narcotics is at present allowed to occur as a direct result of the use of narcotics for genuine health needs—both the principles of good medical practice, and the regulations for control of the use of narcotics for medical purposes, prevent this abuse. Even if an individual physician might occasionally fail to realize that a patient is inadvertently becoming an addict, he is rapidly reminded of it by the Division of Narcotics Control, and must take steps to control the situation, or risk not only his reputation but also his right to practise medicine.

5. So far as we can determine, addiction is mainly to heroin and marijuana. Marijuana is not used for medical purposes in Canada. Heroin has been used

only in mixtures (intolerable by injection) for oral use for severe acute cough, or by injection for advanced cancer cases in which morphine is not tolerated. It is safe to say, therefore, that the two drugs in greatest use by narcotic addicts have hardly been used at all by our profession for medical purposes. Moreover, since the 1st of January, 1955, as you are aware, heroin is no longer available for medical prescription in Canada for any disorder.

6. It is, therefore, fair to assume that the present pattern of addiction to narcotics has no relationship to the legitimate medicinal use of narcotic drugs for the relief of suffering in human disease.

Therefore, Mr. Chairman, it is to be hoped that:

a. The medical profession will not be blamed for the (apparent) rise in addiction to narcotics, and,

b. The present "pleasantly-stringent" regulations for control of the use of narcotics for legitimate medical purposes will not be made "unpleasantly-rigid" as a result of this, or other, investigations.

That is all I have to present, sir.

The CHAIRMAN: So the medical profession states that there is no relation between the administering of drugs for patients and the addicts.

Dr. BAGNALL: No significant relationship.

The CHAIRMAN: There are many of that belief, you know doctor.

Dr. BAGNALL: That is the reason we thought this should be said, sir.

Senator HODGES: In your opinion, doctor, there couldn't be very much else done than the present regulations? I mean, the Medical Profession as a whole is satisfied with the regulations for the use of drugs.

Dr. BAGNALL: Speaking as a whole, I think we are satisfied that they are sufficiently stringent and yet sufficiently usable.

Senator HORNER: Would you like to express any opinion as to any method of dealing with addicts? Have you any suggestions along that line?

Dr. BAGNALL: I'm afraid I haven't, sir.

Senator LEGER: Would you say, sir, that an addict is curable?

Dr. BAGNALL: I'd rather not answer that question because I feel that I am here on behalf of the B.C. Medical Association to put our case for the circumstances under which narcotics are used for medicinal purposes.

Senator HOWDEN: Quite so.

Senator GERSHAW: Mr. Chairman, it was suggested to us in one of the briefs that the distribution of narcotics might be placed to some extent in the hands of doctors. That is, the doctor would be allowed to treat these people and give them gradually the dose of narcotic that he seemed to think he required. Would the B.C. Medical Association approve a plan of that kind?

Dr. BAGNALL: I think that would have to be discussed at length by the Profession and I would again not like to answer that. I think that most of us in practice shy completely away from the administration of narcotics to addicts and, certainly, I think that most of us would just turn down a narcotic if he asked for an injection—even a tapering-off injection. There are certain circumstances and certain situations in which that might be done, but on the whole I think it is a pattern of medical practice to refuse an injection of a narcotic to an addict. That is certainly what the medical students are taught. I'm sorry,—. That is what the medical students are taught. I happen to be responsible for the teaching of therapeutics under the Department of Medicine, under Professor Kerr, and we have to adopt some policy as well as the ethical policies of a doctor adopted by the Association. That is the situation as it is today.

Senator HOWDEN: There seems to be some misunderstanding about this matter of the Medical Profession administering narcotics. I don't think that that is properly presented. I really think that the idea is that the government will have control offices and appointed medical men under salary to administer to such addicts as are very much in need of attention, I think that's the idea. There seems to be a little bit of ambiguity even amongst the members of this Committee.

Dr. BAGNALL: I am sure that the Medical Profession as a whole would subscribe to this. If it is decided to administer narcotics to addicts, it should be done officially and not by the Medical Profession on the whole.

Senator HOWDEN: The idea was that isolated medical men would be employed by the Government.

Senator McKEEN: I take it then, doctor, that what they're somewhat afraid of is that the same thing might happen to drugs that happened with liquor. When they had prohibition here, and a doctor could prescribe for a bottle of liquor, the majority of physicians didn't prescribe it, but there were some that prescribed plenty.

Mr. LIEFF: It was for medicinal purposes, Senator, presumably.

Senator McKEEN: Well, that was the reason given and I think that may have some bearing on the thought that they didn't want everybody—

Senator HODGES: There's one thing I would like to ask the doctor. Doctor, I think you are the first one who has stated that marijuana is used to a certain extent here. Have you found much of it?

Dr. BAGNALL: No, I was talking about the addiction problem. It is in certain places a curable addiction problem.

Senator HODGES: Yes, you mentioned marijuana—

Dr. BAGNALL: I have no knowledge of marijuana being commonly used in Vancouver. No, I was speaking in terms of general addiction. I'm afraid I am on a theoretical level on that.

Senator HODGES: No, it was only a point I wanted to clear up because the question has arisen two or three times and when you mentioned marijuana I thought we would hear your views.

Mr. LIEFF: Did you make it clear that marijuana is not being used at all for medical purposes?

Dr. BAGNALL: Yes.

Mr. LIEFF: And it is so stated.

Senator HODGES: Oh, yes, I understand.

Senator LEGER: Doctor, would you be in favour of having clinics so that an addict could go and get his portions whenever he feels like it.

Dr. BAGNALL: Mr. Chairman, I feel again that I am not qualified to answer that question.

Senator HOWDEN: I don't think it is fair to present these questions to the doctor. He's here representing the Canadian Medical Society.

Senator LEGER: And your personal views?

Dr. BAGNALL: I do not feel qualified to give a personal view on the subject because I have not had enough experience.

Senator LEGER: The reason for me asking you that is, some are in favour and some against and, as a Committee, we would like to have something in the papers.

Dr. BAGNALL: I realize that, but I'm afraid that my contact with addiction is so small that I have no right to say anything as an individual.

Senator HORNER: Do you think, doctor, there are any addicts created through passing through severe illness, where they suffer great pain and are administered narcotics and they become habit forming?

Dr. BAGNALL: I would say the incidence is very slight, indeed, considering the amount of narcotics that are used for that purpose, usually because we are using narcotics for incurable diseases when it is being used in that quantity.

The CHAIRMAN: I'm glad you made that statement, doctor, because it is a very important statement.

Dr. BAGNALL: That was my chief purpose in being here.

The CHAIRMAN: There is a general feeling that a patient does become an addict in the using of drugs in illness.

Dr. BAGNALL: Another thing that I might say on the side, is that I am sure that the amount of narcotics that are obtained from the theft of doctors' bags wouldn't keep very many of the narcotic addicts in drugs.

Senator KING: In other words, the doctors don't carry a syringe in their pockets.

Dr. BAGNALL: No. We do carry a syringe in our bag, of course, for other purposes. But there can be only a very few bags stolen during the year, I don't know what the exact number is, but certainly we all keep a small quantity of narcotics in our bags—a very small quantity.

Senator HORNER: The quantities that might be habit-forming are only administered to a person during his last illness, to relieve suffering.

Dr. BAGNALL: Yes. There are acute cases in which the pain is intolerable, as a heart attack. Morphine is the first drug that we use in a heart attack.

Mr. LIEFF: Do you think the figure of 46 which we have in British Columbia under the heading of "medical" addicts is a reasonable figure, having in mind the amount of drugs which are prescribed for the purposes you have indicated?

Dr. BAGNALL: Does that mean—

Senator LEGER: Became addicts through medicine?

Senator STAMBAUGH: I don't agree. I think that means doctors and nurses.

Mr. LIEFF: No, the figure for doctors and nurses, etc., is 38.

Dr. BAGNALL: I would have to know your definition of an "addict" under those terms, because that might just be a compilation of statistics saying there are so many people receiving more than one grain morphine sulphate per diem and I would have to study that to make a comment, I'm afraid. It doesn't seem like a high proportion.

The CHAIRMAN: Any other questions, gentlemen?

Thank you doctor for appearing before this committee.

Our next witness will be Superintendent J. C. Horton of the Vancouver police.

On behalf of our Committee I welcome you, Mr. Horton.

You may begin.

Supt. HORTON: "Vancouver, B.C., April 20th, 1955. Mr. Chairman and Members of the Senate Committee. You have already been made acquainted with the problem of narcotic drug addiction as it is encountered by the police in Vancouver, through the brief submitted to you by our Chief Constable, Mr. Mulligan, when he appeared before you in Ottawa, March 30th, last. Chief Mulligan dealt with the problem in a general way, and I do not wish to take up your time by going over the same ground that he covered other than to say that I am fully in accord with the remarks and opinions he

expressed and that I most certainly endorse his views that segregation and isolation of the addict is the only effective answer to the problem.

For the police officer the problem is a dual one because, not only does he have to contend with the activities of the peddlers and the addicts insofar as trafficking and addiction are concerned, but he also has to contend with the criminal activities of the addicts in their efforts to obtain the necessary cash for the purchase of drugs.

In my capacity as Superintendent of Detectives in charge of the Criminal Investigation Division of the Vancouver City Police Department I am responsible for supervising the personnel detailed to enforcement of the Opium and Narcotic Drug Act in this city as well as the work of the detective officers assigned to the general investigation of crime. With a large portion of our crime being attributable to the activities of narcotic addicts, you will appreciate that the steady increase in addiction which has become apparent here in the past few years is a matter of grave concern to me personally.

There are approximately 1,158 persons who have been convicted in the last 10 to 15 years under the Opium and Narcotic Drug Act in and around Vancouver, and there are 423 persons here whom the police have reason to believe are addicts. It is estimated that new addicts are being created at the rate of 10 a month. You have already been supplied with statistics showing the gradual downward trend in the age groups of those convicted in Vancouver on charges under the Drug Act, and there is the very grave possibility of even juveniles becoming addicted. This is a situation which no conscientious police officer can regard with equanimity, and I am firmly convinced that if more of our citizens were aware of the full implications of what the increase in addiction means to them personally—of the seriousness of this threat of addiction becoming prevalent amongst juveniles—their demands to you gentlemen at Ottawa that something be done about it would be far more vociferous than has been the case to date.

It has been said that imprisonment is no answer to the problem of addiction, that it provides no cure, and the truth of this statement is fully borne out by our own police records, which show case after case of persons convicted and sentenced to prison terms for possession of drugs being re-arrested on a similar charge within a very short space of time following their release from prison. The police officer's concern, however, is not to find a cure, but to prevent the illicit sale and use of narcotics, and what is more important, prevent the spread of addiction. The only way that the police officer can accomplish this is to apprehend the trafficker or addict in circumstances where there is sufficient evidence to secure a conviction under the Opium and Narcotic Drug Act, this in turn leading to the offender being sentenced to a prison term and thus removed from society.

It is logical to assume that the greater the number of addicts convicted and sentenced to imprisonment, the less chance there will be of others becoming addicted, for it is the addicts themselves who are chiefly responsible for initiating others into this vicious habit. It follows then that an intensified enforcement program would have some beneficial results. If I could divert the entire strength of my Detective Division to checking the activities of traffickers and addicts, this would result in increasing the number of arrests and reducing the number of addicts loose in the city at any one time. However, it is not possible for me to assign the number of officers that would be required to maintain a continuous twenty-four hours a day vigorous attack on this problem, and the budgetary restrictions placed upon the City Police Force makes it impossible for us to recruit sufficient new men to replace the number of detectives that would be required to be withdrawn from service for special training in narcotic work and then applied to enforcement.

My thinking, then, has to be how to obtain the best results with the men and resources at my command, having regard, of course, to the provisions of the Opium and Narcotic Drug Act. In regard to the latter, I have a suggestion I would like to place before you for consideration which, if implemented, would, I feel, assist the police immeasurably in securing convictions. Your attention has already been directed to the difficulties confronting the police in their efforts to secure the necessary evidence on which to base a prosecution for drugs in possession; you know that under the Opium and Narcotic Drug Act the drugs in possession must be actually produced. You know that the drugs are put up in very small capsules which are easily hidden, and you are aware of the techniques of the addicts first as regards eluding the police and then of disposing of the incriminating evidence by either flushing the drugs down a toilet or swallowing them if the police are successful in surprising them. It is particularly galling to a police officer after spending hours and hours of his time in trailing a known addict and keeping his room or hide-out under observation waiting for an opportune time to make an arrest, to see the suspect calmly swallow the evidence, knowing full well the police officer is powerless to take any further action at that time.

I would like to quote to you, Mr. Chairman, an excerpt from the Gaol Rules and Regulations made pursuant to the "Police and Prisons Regulations Act" of British Columbia. Section 50A of these Regulations reads as follows:

50A. If the Warden has reasonable grounds for suspecting that a prisoner on admission to the Gaol or on re-admission after temporary release from Gaol for purposes of attending Court or otherwise, had concealed in his or her body any opium or narcotic drug within the meaning of the 'Opium and Narcotic Drug Act', or any other contraband article, he may,

- (a) cause the prisoner to be held in quarantine or close custody for such period as is necessary not exceeding ten days, to ascertain whether or not drugs or other contraband articles are being so concealed, or,
- (b) cause the prisoner to be examined by the Medical Officer and given such treatment as deemed necessary to expel or recover the drug or other contraband article which is suspected of being concealed in the body of the prisoner, using such force only as is necessary under the circumstances.

I believe, gentlemen, that similar authority granted to the Chief Constable or Chief Officer of Police would be of inestimable value to the police in combating the problem of narcotic drug addiction. The situation we are facing is that the techniques of the addicts to avoid detection and apprehension have advanced beyond the techniques that the police are permitted to use in the apprehension and conviction of the addicts. To strengthen the position of the police, I would therefore suggest the following amendment to the Opium and Narcotic Drug Act.

If the Chief Constable has reasonable grounds for suspecting that a person has concealed in his or her body any opium or narcotic drug within the meaning of the "Opium and Narcotic Drug Act", he may cause that person to be held in quarantine or close custody for such period as is necessary, not exceeding 24 hours, to ascertain whether or not drugs are being so concealed, or, "cause the person to be examined by a physician and given such treatment as deemed necessary to expel or recover the drug which is suspected of being concealed in the body of the person, using such force only as is necessary under the circumstances.

It can be anticipated that there will be some objection to legislation such as I have suggested. Some people will take the attitude that it is an infringement of the rights of the individual. I would point out, however, that if an addict with drugs in his mouth is seized by the narcotics officer in time, it is sometimes possible to recover the drugs with the application of a certain amount of force, that is, the addict is forced to open his mouth and the drugs are removed by the officer who then has the necessary evidence on which to lay a charge. All that this amendment would do is to authorize the development of this recovery technique a little further. That is to say, in cases where the addict is seen by the narcotics officer to actually swallow the drugs, the addict would be taken into custody where the drugs would be recovered under medical supervision on authority of the Chief Constable.

I would also emphasize that in the selection of officers for narcotic work, mental ability rather than physical ability is the primary consideration. Narcotic officers are selected for their interest in this problem and desire to protect society against narcotic addiction. These officers must be specially trained for the work, and they are not the type of individuals who would abuse special powers conferred upon them.

At the present time penalties do not deter an addict or trafficker because he is not certain of detection. The adoption of this amendment would act as a deterrent as it would ensure that certainty of detection.

I feel that adoption of the suggested amendment, coupled with implementation of Chief Mulligan's suggestion of complete isolation of convicted addicts, would result in effective curtailment of the menace of narcotic drug addiction in this city within a very few years.

Mr. LIEFF: Superintendent, I wonder if you could just add to what you have said, if you know of any jurisdiction that has that sort of a law.

Mr. HORTON: That was put into force in 1954, January 26th, and they have that law in Oakalla Prison Farm at the present time.

Mr. LIEFF: Yes, but are those men who are convicted already. People who are convicted or who have charges pending.

Mr. HORTON: The individuals that are dealt with there are subject to charge. It is quite true.

Mr. LIEFF: Yes.

Mr. HORTON: But they are not convicted of any crime at that time, they are just individuals awaiting trial.

The CHAIRMAN: Awaiting trial?

Mr. HORTON: Awaiting trial.

Mr. LIEFF: Yes, I appreciate that, but apart from British Columbia or Oakalla, do you know of any other jurisdiction which has this kind of law?

Mr. HORTON: I do not, sir.

Mr. LIEFF: Thank you very much.

Senator HODGES: One thing I would like to ask the Superintendent. I notice that he says that a large proportion—that a large portion of our crime is being attributable to the activities of narcotic addicts. We have had the statement made before this committee that far more crime is attributable to alcoholism rather than drug addiction. You apparently don't agree with that statement?

Mr. HORTON: I do not, Senator.

Senator McKEEN: The figure given to us that, of the crimes committed and criminals convicted, there was only 30 percent at the best that were drug addicts so that would leave 70% who were not drug addicts. You say those figures aren't right?

Mr. HORTON: Well, I can only give you the figures such as we have of the known addicts in the City, those that are suspected. There are others that we do not know of. The amount of crime, which I think you have figures on, shows a certain amount. There has also been, (I may be corrected on this) evidence given that to keep up the narcotics addiction would cost that much more than the actual crime—the cost of crime—that is reported in the City. A lot of this shop-lifting, and there is an awful lot in this City, we do not receive any reports of and therefore we can only put it down to a certain class of individual. You mentioned the alcoholic. The alcoholic that usually goes in for shop-lifting, or crime, he is usually caught in view of his actual condition, but an addict is a smart type of operator. His senses are more keyed up than a person that is under the influence of alcohol.

The CHAIRMAN: I think Magistrate Orr gave us the viewpoint, or the figures that there were more than half a million—

Senator HODGES: 554,000—

The CHAIRMAN: Yes. Others had been stating as high as 10 million. Now the figures are so—

Mr. HORTON: Mr. Chairman, may I answer in this way.

Was the ten million given as a figure that was required by the addict to supply the narcotic addiction?

Senator HODGES: No, no, the cost of crime in Vancouver was estimated at about ten million dollars through drug addiction. But Magistrate Orr gave us the figure of \$554,000 as the total cost of crime. When I say the "cost of crime" I mean things stolen, with the exception of automobiles. The amount of property stolen amounted to \$554,000.

Mr. HORTON: I perhaps cannot give you the answer you are looking for. All I can say is that we have a reported crime of \$500,000 in the City of Vancouver. I think that was the figure.

Senator HODGES: \$554,000?

Mr. HORTON: \$554,000.

Senator HORNER: Over the last ten years I think—

Mr. HORTON: But, we do have a much greater crime loss which is not reported, which is not attributed, but which we can't attribute to anything other than crime. Take it this way. Your big stores have a terrific loss which they put down to shrinkage but the biggest percentage of that is from theft.

Senator HODGES: They don't report it?

Mr. HORTON: Well, they're not in a position to. I'll give you an instance. One of the big stores just recently reported the loss (some weeks after) of two \$700.00 fur coats. They don't know how they went. They're not there. Now, they cannot say it was theft from an outside source, or whether it was inside, they only know it was on the premises, but it is a loss.

Senator McKEEN: It might not be a drug addict.

Mr. HORTON: Quite true.

The CHAIRMAN: The statement has been made, unofficially so far, we're trying to get an official statement that in checking up the largest—two or three of the largest—departmental stores here, who also have departmental stores in Winnipeg, that the loss is no greater in spite of the fact that we know we have a great drug population. Now, they reported the losses are no greater in the City of Winnipeg than they are from the general stores here, the percentage of loss.

Senator HODGES: The point is, superintendent, that the statement has been made public, and publicized in the press, that through drug addicts ten million dollars in yearly losses is occasioned—

Senator HORNER: In crime,—

Senator HODGES: Well, I mean, in crime, the cost of crime in Vancouver is ten million dollars a year. There is such a wide discrepancy between the \$554,000 and \$10,000,000, that is why I would like to get your point of view.

Mr. HORTON: I'm sorry, I wouldn't like to say any more in respect to that other than what I have said.

Senator HORNER: You were going to say there that you reckoned it would take nearly that to keep all those addicts in a supply of goods?

Mr. HORTON: I don't know the exact figures, but if you take, supposing we have a thousand odd addicts here in the City of Vancouver, they require, we'll say, ten dollars per day each over the year, that would amount to a vast sum.

Mr. LIEFF: How many addicts did you say?

Mr. HORTON: My figure is 1,158, but I think there are a few more since this figure was given.

Mr. LIEFF: Yes. Well, let's just examine that 1,158. How many of those would be in jail at any one time?

Mr. HORTON: I couldn't give you the exact figure, sir, but I would say—

Mr. LIEFF: Roughly—

Mr. HORTON: —a quarter of them.

Mr. LIEFF: A quarter of them always in jail?

Mr. HORTON: I would say so.

Mr. LIEFF: So that we haven't the 1,158 any more. Now, of the remainder would it be fair to say that a large percentage of them are women?

Mr. HORTON: I would say that—

Mr. LIEFF: 25 per cent?

Mr. HORTON: Yes.

Mr. LIEFF: So, we'll take that other figure and we'll break that down—we'll take a couple of hundred off 1,100 and we have 900; and we'll take 25 per cent off for women, because they're prostitutes, they're not shop-lifters—the women—

Mr. HORTON: Oh, yes, they are.

Senator HODGES: Oh, yes, they are.

Mr. LIEFF: Aren't they, to the most extent, prostitutes?

Mr. HORTON: They follow any type of trade where they can get money.

Mr. LIEFF: And don't they often support the men?

Mr. HORTON: They do support men, yes, but they shop-lift as well.

Senator HOWDEN: Mr. Chairman, you made a remark about Winnipeg which I rather resent. You said that there was no greater amount of shop-lifting in Winnipeg than there was in Vancouver. Our addiction problem in Winnipeg is transient; we have very few resident, permanent addicts and why the devil should it be greater in Winnipeg than here.

The CHAIRMAN: I said it is not greater—

Senator HOWDEN: Then why did you say so? You said it was no greater in Winnipeg than it is here.

Senator HODGES: In proportion.

The CHAIRMAN: In proportion, I said.

Senator HOWDEN: Well, you didn't say in proportion.

The CHAIRMAN: I'm not running down Winnipeg.

Mr. LIEFF: I have an item from today's press which reads as follows: "Addicts cost City millions" (I'm not going to mention the source), but here's what it says: "... estimated on Monday that drug addicts are costing Vancouver between sixty and one hundred and fifty thousand dollars a day." Parenthetically, that would total between twenty-one million and fifty-four million annually.

What would you say about those figures?

The CHAIRMAN: A slight exaggeration?

Mr. HORTON: I would say the addicts are costing this city a lot of money.

Senator TURGEON: Mr. Chairman, I would like to ask the witness one question. I have in mind your recommendation, Mr. Horton, that additional power be given to the police for examination of suspected addicts. We have been told that there is very little responsibility for the crime of selling drugs attached to addicts themselves. I gather from your recommendation for increased power to examine addicts that you wouldn't agree with that. We have been told that very little of the cause of sale of drugs is applied to addicts, themselves.

Mr. HORTON: I am suggesting that this new legislation be put into effect both for the addict and the peddler.

Senator TURGEON: Do you agree that there is only a very small share of the responsibility attached to addicts? Or do you think that the addicts are largely responsible for the increasing sales?

Mr. HORTON: Yes, it is the addict—

Senator TURGEON: I don't mean by increase in purchase by themselves but increase in sales to others.

Mr. HORTON: It is the addict who creates the addict and it's the addict that creates the sales. For that sale you must have somebody to supply that market and you have the "pusher" or the "peddler". Now, there are two detectives (Messrs. Cray and Mead), I don't know, Mr. Chairman, whether you will call them, they are here this morning,—

Mr. HORTON: They are in a position to give you anything, or answer any questions with reference to drug addiction, peddling, the operation here in the City of Vancouver. They know them all by name—

The CHAIRMAN: They are very close to them—

Mr. HORTON: Very close. And, at a later date, if it meets with your approval, on Thursday we have made arrangements whereby members of your Committee can see the actual transaction between the addict and the peddler. This will be explained to you and you will see the individuals.

Senator STAMBAUGH: Mr. Chairman, I want to ask one question. Do you consider a large number of addicts are also peddlers; the large proportion, I'll put it that way.

Mr. HORTON: No, I think the figure will be given this morning that there are about 24 peddlers in the City of Vancouver, so the proportion of addicts is much greater.

Senator STAMBAUGH: The percentage is not very large then in that case.

Mr. HORTON: No.

Senator LEGER: Mr. Chairman, the witness says here there are 1,158 known addicts within the last ten to fifteen years and there are 423 of them—there would be more—

Mr. HORTON: Not of them. Of addicts yes.

Senator LEGER: —then you are not positive that they are addicts but you think they are. They have never been in Court in other words?

Mr. HORTON: They have never been in Court.

Senator LEGER: That would increase the number to fifteen hundred and eighty-one.

Mr. LIEFF: I just want to clear up the question of the power that the Warden at Oakalla has to make a prisoner regurgitate, or that sort of thing, so that you could recover the evidence. You just want that extended so that you can hold a man for twenty-four hours and on the word of the Chief of Police it would be exactly the same thing.

The CHAIRMAN: Let him answer that.

Mr. LIEFF: Yes, I'm sorry.

Mr. HORTON: I mentioned that that authority should be given to the Chief Constable only, and then the operation would be put into effect by the Medical Officer.

Mr. LIEFF: They can do that at Oakalla?

Mr. HORTON: Yes.

Mr. LIEFF: You have a man dealing with a fellow who has just swallowed some of the drugs. What is wrong with laying a charge against him and taking him out to Oakalla in twenty minutes?

Mr. HORTON: We can't send them out to Oakalla—

Mr. LIEFF: Can't you?

Mr. HORTON: We have no charge.

Mr. LIEFF: But if you lay a charge—

Mr. HORTON: Of what?

Mr. LIEFF: Of having possession—

Mr. HORTON: You can't do that, sir.

Senator HOWDEN: How would you go about recovering a swallowed capsule, giving them apomorphine or something of the kind?

Mr. HORTON: I don't know what to give him, sir, but I am sure the Medical profession could give him something—

Senator GERSHAW: Would it involve washing out his stomach?

Mr. HORTON: It may do so. It may involve giving him an emetic—

Senator GERSHAW: That's an extremely advanced, almost a dangerous step, there is danger involved—

Senator HOWDEN: There won't be much danger involved in giving a man apomorphine.

Senator GERSHAW: A man's body is pretty sacred and no one could do anything without his permission. Could not that be accomplished in some other way, by keeping him for a longer time and getting the evidence in that way?

Senator HOWDEN: The results of the bowels would be pretty badly deformed by the time they—

Mr. HORTON: You see what we mean, Mr. Chairman, we arrest an individual who has swallowed a narcotic. We would take him to the police station. At the present time we have no charge, therefore we cannot hold him. We

cannot take him into custody. What we are asking is that this man be taken into custody and extend our power just a little bit further whereby we can remove the drugs from his body under the supervision of a doctor. At the present time we go just so far—we do hold the individual and force him to open his mouth and—

Mr. LIEFF: Regurgitate—

Senator HOWDEN: You can't look down his stomach.

Mr. HORTON: Yes. But that's as far as we go and once he has it past his throat we can't do anything further.

Senator HOWDEN: But you could, under medical supervision—

Mr. HORTON: We could quite easily.

Senator HOWDEN: —give him drugs that would promptly eject them up through the throat or you would recover them in the stool perhaps, but it wouldn't be very difficult.

Mr. HORTON: That's right.

Mr. LIEFF: What do you do with your remand prisoner when you bring him in and lay a charge against him? Where do you put him?

Mr. HORTON: Sometimes he is remanded to Oakalla, sometimes he is kept in the City lock-up.

Mr. LIEFF: Exactly. Now you have a man whom you know, whom you've seen swallow drugs, why can't you lay a charge against him and remand him to Oakalla and let them do the job?

Mr. HORTON: I'm afraid, sir, we haven't the evidence.

Mr. LIEFF: You know you'll have it later.

Mr. HORTON: That may be so, but—

Senator HOWDEN: It just depends on how much later they examine him.

The CHAIRMAN: They might not.

Mr. HORTON: Supposing he had a capsule and he swallowed it, we have a charge but we have no evidence.

Mr. LIEFF: You may or may not have it even at Oakalla.

Mr. HORTON: At Oakalla they're not altogether sure what they're getting, but I'm asking, sir, that when we see the evidence—

The CHAIRMAN: I have a further question I would like to ask you. You make the statement that new addicts are being created at the rate of ten a month. Have you evidence and facts to bear that out? And also I notice you point to the problem of a greater number of juveniles becoming addicted, can you enlarge on that?

Mr. HORTON: Answering the first question, this is something that was given to me by the other two witnesses and we will have figures with reference to that. I am informed that there is an increase of addiction, or new addicts, at the rate of ten a month.

Regarding the juveniles, I think you have before you sir, an appendix whereby it shows the age limit is gradually dropping. Now what we are afraid of, I attended a meeting here in the City of Vancouver in connection with the School Board; they were somewhat concerned over the drug addiction in the City and they were much concerned whether this had reached the school children in the City of Vancouver.

The CHAIRMAN: Was there any evidence—

Mr. HORTON: We had no definite evidence. Everything that was reported we checked out and we did not find any. There is the possibility that, if something drastic is not done, it will eventually reach the school children. It

has reached children of school age but not actually school children. A person might be sixteen or seventeen, they're school-age children but not school children.

Senator HODGES: We have also had the statement made that in the majority of cases of these younger people, most of them have a delinquency background before they take to drugs. Have you found that, superintendent?

Mr. HORTON: I think that is right.

Senator HODGES: I mean, they're delinquents before they are addicts?

Mr. HORTON: Usually, because they have to come from a certain background before they can become, or get acquainted, or get in to get the drug.

Senator McKEEN: Mr. Chairman, I have another question. You state in your brief if you had more trained officers that you could do a better job in the city of Vancouver. How many do you think you would need? How many extra?

Mr. HORTON: Well, I cannot give you a figure on that because—

Senator McKEEN: Well, what's your opinion?

Mr. HORTON: My opinion is this. I suggest that we could do a better job but it would only be just a stopgap for this reason,—that addiction breeds addiction and the longer we let it go—well, today I could do with twenty men but at the rate the addicts are growing we would need so many more next year.

Senator McKEEN: I'm dealing with today. You say possibly you would need twenty more men?

Mr. HORTON: Well, sir, I would say we would need double that at the present time to do a really good job.

Senator McKEEN: You could do with forty men?

Mr. HORTON: Yes.

The CHAIRMAN: To take care of the present situation?

Mr. HORTON: I'm not saying that would take care of the situation.

Senator McKEEN: I want to get to some definite point here because you have made the statement that if you had more—now, how many more?

Mr. HORTON: I'm afraid, sir, I couldn't answer that.

Senator McKEEN: Why I was asking that question, I understand you work with the R.C.M.P.

Mr. HORTON: We do, yes.

Senator McKEEN: Have you had requests to the R.C.M.P.—(they have this type of men) for men and been turned down?

Mr. HORTON: No, we have never been turned down by the R.C.M.P.

Senator McKEEN: Well, then, I would say that men are available until you ask for them and are turned down.

Mr. HORTON: No, sir. I think their Department is working to its limit right now as far as the narcotic question is concerned.

Senator McKEEN: Well, if you haven't been turned down, you don't know that, because they have men all over the Dominion. I don't say for the regular policing of Vancouver, but you're discussing here drug addiction, and I understand under the Narcotic Act they work that and I think what we should do here, if you need extra men, is that (up to the point where you are turned down by the Dominion) we can't say we haven't got men enough.

Mr. HORTON: I can say, sir, we haven't been turned down in any request.

Senator McKEEN: Thank you, that's all.

The CHAIRMAN: Any further questions, gentlemen? If not, may I express our thanks for your appearing here today Superintendent Horton.

Detective Rex Cray is next on the list. Mr. Cray, I want to thank you and welcome you on behalf of our Committee.

Mr. CRAY: Mr. Chairman and Honourable Senators—

Senator HODGES: Would the detective mind waiting until we get the briefs?

Mr. LIEFF: Mr. Chairman, this is a joint brief and perhaps we might introduce the co-author, Detective Clifford Mead, who is at the head of the table here.

The CHAIRMAN: Detective Mead we are very glad to have you with us. I suppose you will be prepared also, Mr. Mead, to answer questions?

Mr. MEAD: I will, sir.

Mr. CRAY: Before I go into this brief, I would like to say that this is a joint brief prepared by myself and Detective Mead. We worked together, at least he has been with me for six years in narcotic enforcement and we are both in agreement on this brief and we will both be available for questioning regarding this brief or any other questions which you care to ask us concerning it.

This is a brief prepared by Detective Clifford Mead and myself and presented to you with the hope that our intimate experience with addicts and drug peddlers will be of some assistance to you in your present investigation. For the past nine years I have been engaged in narcotic enforcement, and for six of those years I have had Detective Mead as my partner. During this time we have had countless opportunities to observe the drug addict and the drug peddler in their natural environment. On a great number of these occasions they did not know that they were under police surveillance, and therefore we believe that we have obtained a reasonably true picture of the situation. Our work involves knowing the addicts and peddlers; where they live; how and where they peddle drugs; how and where they use the drugs; and what precautions they take to evade detection. Under the provisions of the Opium and Narcotic Drug Act it is necessary for us to obtain physical possession of enough narcotic drug to be analyzed by the Dominion Analyst. It is not enough for us to know or suspect that a person is in possession of drugs, if he is successful of disposing of them on our approach. The peddlers and addicts use many and varied methods of avoiding arrest.

The peddlers we have here fall into two main categories at the present time. The street peddler, and the peddler that operates by telephone and automobile. The street peddler usually sits in a beer parlour, cafe or pool room, and awaits the drug seeking addicts. He may have a man called a "stearer" walking around the streets telling his location to any addicts who want drugs. The peddler of this type is very careful to sit facing the entrance, and usually with his back against a wall, and with the drugs in a rubber container in his mouth, so that he can swallow them immediately he sees a police officer enter. These drugs in this watertight rubber container can easily be vomited up, intact, when the police have gone. The addict on contacting the peddler will pay his money and receive his capsule in return. The peddler may take the drugs out of his mouth where he is and pass the drugs, or more often he will go to the toilet and lock himself in one of the cubicles and take out the number of capsules wanted there. In this way he protects himself from the police, for if the police try to catch him at this point by breaking into the cubicle, all he has to do is flush the drugs down the toilet. A variation of this method frequently used by the peddler is that, after receiving the money from the addict, he will take the addict to a nearby street or lane, where he has previously concealed drugs, and complete the transaction there. To apprehend this type of peddler we must quickly seize him, before he is aware of our presence,

and extract the drugs from his mouth before he can swallow them. This is usually quite difficult. Frequently we see the peddler swallow the drugs before we can get to him, and we have no power to recover them. Our laws do not permit the use of an emetic or laxative.

In the second method the addict will phone the peddler, who will take his order and tell the addict to wait on the corner of two intersecting streets, usually away from the downtown area of the city and away from the greatest police concentration. This peddler has a man or two men, driving around in an automobile, who have the drugs, and who phone in at least every half hour and get the locations where the addicts are waiting. There are usually no drugs at the location of the telephone number. The men in the car drive to the locations given, and pick up the addicts, and drive them around a short time while the transaction is taking place in the car, and then let them out quickly, and continue on to sell to the next addict at another location. We have found it very difficult to catch the man selling drugs in the car because he keeps the windows and doors locked, and calmly swallows the rubber containers of drugs, while we are trying to break the windows and get into the car. They are always looking for a police car following them, and are very difficult to follow. A variation of this method is found when the peddler has only one man frequenting drug addicts' hangouts, where he meets the addicts, does the phoning himself, and arranges a meeting with the car.

Owing to the fact that most street peddlers are addicts themselves, they are very often arrested while using drugs. This is recorded as a Possession Conviction when in reality a trafficker has been caught. For this reason a clear cut distinction cannot be drawn between addicts and peddlers. Many addicts peddle drugs from time to time and many peddlers stop selling and revert to their addict status.

The addict after obtaining his drugs will immediately wrap them in silver paper or place them in a rubber container and put them in his mouth, so that he can swallow them if he is accosted by a police officer, and of course, vomit them up intact upon his departure. The addict will usually go immediately after he has bought his drugs and take his "fix" or injection. If he is "fixing" in his room, he will go there first to see if there are police awaiting him, and then he will pick up his drug paraphernalia, which is usually secreted in the hallway, toilet or bathroom. Then he will lock himself in his room, and often barricade the door with a bed or dresser. It will take him from 5 to 10 minutes to prepare, use the drug and clean up the equipment. Often in order to avoid the danger of drugs being found in his room, the addict will fix in such places as public washrooms; parks, under docks, on small boats; and even in open fields.

In our experience we have not encountered a single case where a confirmed addict has permanently relinquished his habit. Many people assure us that they have broken away from their addiction, but sooner or later we find this to be untrue. In fact, an addict is a slave to heroin and lives for nothing else. He does not care about his wife; his children; his friends; his health; his cleanliness; his clothing or his appearance. He does not care about society nor does he lead a useful existence. In most cases he has a criminal or delinquency record before addiction. He has few morals and very seldom tells the truth. In spite of the fact that it is said that narcotics do no specific harm to the body, most addicts appear to be in poor health, frequently being emaciated and sallow. There is a marked improvement in their physical appearance after a period in prison.

It is estimated that our peddler and addict population is around 1500. This includes some 500 in prison, but does not include an undetermined number who have not yet become known to the police. Therefore it is conservative to

say that we have around 1000 addicts in and around Vancouver. An average addict must have at least 3 capsules a day to keep him satisfied. This works out to over a 1000 capsules a year at a cost of around \$5,000.00 at the present price to each addict. This money is obtained almost entirely from some type of crime, such as theft, breaking and entering, robbery with violence, false pretences and forgery. Prostitution provides money for the majority of the female addicts, each of whom usually supports a male addict. Of course those peddlers who are addicts get their money from their drug sales. Other less reliable sources of money for addicts are friends and relatives who can be induced to make loans that are rarely repaid. Some are adept at gambling and recently many addicts have found that they can get Social Assistance in the form of cash from the City.

The kind of people who become addicts have been ably described to you by previous speakers, but the important question arises, "How do they become addicts?" From our observations, we are convinced that no person becomes addicted unless he has first associated closely with addicts. It is comparable to the spread of a contagious disease and a disease that up until this time is practically incurable. We have seen young women become infatuated with male addicts and soon become addicted. We have seen men become entangled with female addicts and soon become addicted. We have seen men and women, after becoming friendly with addicts of their own sex, start using drugs. We have seen alcoholics switch to the use of drugs, again after associating with addicts. We have seen young people become users as a result of misguided hero worship of so-called "big shot" addicts. The addiction was not forced on any of these people, the habit being acquired voluntarily. The usual pattern being familiarity, curiosity and eventual experimentation. We have found no case where a person has suddenly decided to start using drugs on his own. Even should a person so decide, he would be unable to obtain drugs without first consorting with an addict and so becoming known and trusted by the peddlers. For peddlers, contrary to general opinion, do not try to enlarge their clientele by selling to unknown people. They are extremely cautious and only sell to known addicts or those vouched for by known addicts, even in some cases requiring the buyer to use drugs in their presence. Obviously, if peddlers were to sell to anyone, it would be a simple matter for an undercover police officer to obtain evidence of trafficking.

It has been suggested that in order to eliminate traffickers and cut down the cost of crime to the community, addicts be registered and given drugs at government operated dispensaries. On the surface this would appear to be an easy solution, however, there are many dangers which must be considered. The greatest of these being the almost certain spread of the habit. The elated addict getting an unlimited supply at practically no cost would without doubt influence others to try drugs. Those susceptible would feel free to experiment, safe in the knowledge that there would be no penalty and very little cost should they become addicted. It is known that the body builds up a tolerance to heroin requiring increased doses to satisfy the craving. This being so, an addict given minimum dosage, as is usually suggested, would not be satisfied; but would augment his supply by again turning to the street peddler. Criminal addicts, who felt they were wanted by the police for some crime, would be afraid to appear at a dispensary and would be obliged to patronize the peddler. Abuses that could arise, if addicts were given drugs to take away for self-administration, are obvious. Non-addicts could register, receive their drugs, and then sell them. Registered addicts could spread the habit by giving or selling part of their own supply to others. The drugs could be used promiscuously in front of anyone. On the other hand the problem of administering drugs at a clinic would be so large as to be impracticable. Clinics would have to be available 24 hours a day as the average addict needs

drugs at least every six hours. There is no doubt that free dispensaries would cut the communities crime costs, but we feel that this would be more than offset by the increased number of lives destroyed by narcotics.

We feel that rather than concentrate our resources on the monumental task of attempting to cure and rehabilitate our present addicts we should direct our efforts to prevent others, and in particular our young people, from being contaminated. As, in our opinion, the overwhelming cause of increased addiction is the addict himself, we feel that the removal of this source would be a great forward step. To accomplish this, all addicts would be detained indefinitely in some suitable institution, until some means is found of permanently curing them. While this may be an unpopular move, it would have the virtue of removing the greatest cause of addiction. It would also destroy the large and lucrative market which enriches the drug syndicates. An indefinite term of detention should certainly prove to be a powerful deterrent to those inclined to try drugs. Coupled with this should be severe penalties for those found engaged in trafficking. We would also suggest that an educational program be instituted both in the schools and elsewhere to stress the dangers and evils of the use of narcotic drugs.

As police officers engaged in narcotic enforcement, we have had the opportunity of seeing the results of drug addiction as few other people have. As citizens of Vancouver and parents ourselves, we are vitally interested in protecting not only our own children but all young people from becoming slaves to heroin. It is with this in mind that our submissions are made.

Mr. LIEFF: Mr. Cray, yesterday we had a very interesting suggestion made by a witness toward the end of the day, who suggested that we provide some sort of treatment for addicts, but if they didn't want the treatment they would be provided with free drugs, whether they worked or they didn't work, and if necessary keep them on Social security. Knowing addicts as you do, and given that choice (either of taking treatment or getting free drugs) what percentage would take the treatment, do you think?

Mr. CRAY: If they were to be given drugs or take the treatment?

Mr. LIEFF: Yes.

Mr. CRAY: They would all take the drugs, they wouldn't take the treatment.

Mr. LIEFF: They would all take the drugs in your opinion?

Mr. CRAY: Yes, sir.

Mr. LIEFF: Thank you very much.

Senator HODGES: I would like to ask the Detective one question. I notice on page 4, you say that "addiction is not forced on any of these people, the habit being acquired voluntarily; the usual pattern being familiarity, curiosity and eventual experimentation", and yet I notice on page 5 you said we would also suggest that "an educational program be instituted both in the schools and elsewhere to stress the dangers and evils of the use of narcotics". Don't you think that by instituting such programs in the schools that you might create just that very feeling of curiosity and eventual experimentation?

Mr. CRAY: In my brief I have stated that the evils of narcotic drugs—not the mechanics of how they are used, or anything like that—be given in the education. In the other part of the brief we mention "familiarity, curiosity and experimentation". You will find that persons who associate continually with drug addicts, and are in their company, they get familiar to and trusted by the addict, see them sticking a needle in their arm three times a day, are trusted to be present when they use drugs, and they hear the addict talk about nothing else but drugs most of the day that they're with him, and they get the idea that there must be something to it and sooner

or later they try the drugs themselves. Whether some of them are asked by the addict to try it and some of them are curious, it follows almost surely that they will try drugs and if they once try it, it is my opinion that it won't be very long before they're addicted. Now, in the school part that I mention, I would only stress the evils—say, once you start drugs you can't stop, and you could show them pictures of addicts before and after, show them the terrible toll it takes by the physical conditions it produces in the body, they become very sallow and if we don't catch them very often you will notice they become very emaciated and sallow.

Senator HODGES: On the other hand, you get safety campaigns for driving and pictures to show them what happens if you're not a safe driver; I mean, too much speed, and that sort of thing. I haven't noticed that that has been any deterrent and children, I mean, being naturally curious and inclined to experiment, it's just a question—there seems to be a division of opinion as to whether education on the part of the schools would be effective.

Mr. CRAY: Yes, but they read all about it in the newspapers, everything there is to know about drugs, but I am not stating that they are going to bring that forward in the schools, just point out the dangers so at least some of the younger girls, when they run into these young fellows who are interested in getting them on drugs and turning them out for prostitution, will at least be on their guard and know what they are getting into. Now we have younger women being introduced to drugs by young men addicts and they don't know what they're getting into until it's too late.

Senator HODGES: At the same time those young girls also read about it in the newspapers. They should know from what they read in the newspapers. If you work it out to a logical conclusion—

Mr. CRAY: They should, but they don't.

Senator HODGES: No.

Mr. CRAY: It doesn't seem to be impressed on them. You might say now my young fellow is thirteen and he knows all about drugs and I'm very sure from what he's been told that I'm not worried one bit that he is ever going to become an addict because he knows all there is to know about it.

The CHAIRMAN: There are two questions I would like to ask you, inspector. One is, from your great experience, you would say that the spread of addiction comes from the drug addict himself and not from the higher ups? The association with a drug addict. You say in your brief here that they are afraid to sell to a new customer unless he is a drug addict in case he may be a police in disguise.

Mr. CRAY: Yes, sir, they are very careful.

The CHAIRMAN: And from your experience, you would say that the real spread of drug addiction comes because someone associates with a drug addict?

Mr. CRAY: That is absolutely correct.

The CHAIRMAN: And sees it used.

Mr. CRAY: I know of no case where a person all of a sudden decides to go down to the street and buy drugs, and even if he did so decide he would not be able to buy drugs from any of the peddlers that are down there at the present time, even if I pointed them out to him and said here's five dollars, go and buy some drugs. He would never be able to buy from any of those peddlers without first associating with an addict, vouched for by an addict or else going with the peddler and using drugs in his presence.

The CHAIRMAN: So the peddler is not the cause of the increase, it is the addict?

Mr. CRAY: It is the addict that causes the increase.

The CHAIRMAN: And the association with the addicts?

Senator HOWDEN: He couldn't exist though, if it wasn't for the peddler.

Senator HORNER: I can see your point, and it might be necessary to educate the young girls to see how a man desperate for money might persuade some of these girls to start in order that he might make a living from them and get the money for his drugs.

Mr. CRAY: They do it all the time.

Senator HORNER: And that is one thing you think is going on, that you fear?

Mr. CRAY: I know it is going on.

Senator HORNER: I can understand that.

Senator HOWDEN: Witness, this question of the peddler and the addict and all that sort of thing, to me it appears that they are all in a necessary chain.

Mr. CRAY: Yes, but you must have the drug market. When you have a large market then you attract a large number of drug rings. If you only have a small market, like they do in some cities where there are only ten or twelve addicts, you don't have any trouble with a large drug syndicate or ring, because there's not enough market there for them to bother about.

Senator HOWDEN: There must be the peddler and there must be the addict and all that sort of thing, and the whole total makes a necessary chain of connection.

Mr. CRAY: That's true, but I still state that it is the addict that starts the new addict.

Senator HOWDEN: I know, but if there were no addicts there probably would be no more addicts.

Mr. CRAY: That is quite true. If you took them all out of circulation then there would be no—at least it would be cut down considerably—cause for the increase of new addicts. If you leave all these addicts out like they are at the present time, roaming around at will in Vancouver and other cities, think how many more there are going to be ten years from now.

Senator HOWDEN: On the other hand, if you had no peddlers you wouldn't have any addicts. If you had no peddlers that made it possible for these addicts to get the drug then there wouldn't be any addicts.

Mr. CRAY: I don't see that because they would get drugs from the drug stores. They would break in and get the drugs some way or other.

Senator HOWDEN: Well I know, there's always a way I suppose.

Senator KING: We have had a description given to us of the addict. I would say he would be a poor salesman. He deteriorates in health, he deteriorates mentally, and I can't understand, if the description given of the addict is correct, how it would be a means to induce people to become an addict. There's something before that. He must be one of weak mind or delinquent of some kind before he will be attracted. Any boy or any girl with normal intelligence would avoid the type of people you describe as addicts. I think you have to go back of that.

Mr. CRAY: Some of the younger ones, as I mentioned, come in contact with a girl, they are not all emaciated and fallow. We arrest them from time to time, and when they go to jail and come out and are in good shape, they've gained thirty to forty pounds in lots of cases, and they have their health back and they are very presentable and good-looking young fellows. And it is very unpredictable what a girl or woman will do if she is infatuated with a man. She'll follow along with him very closely and take drugs without much persuasion. We've found that happen.

Now, as you say, it takes a certain class, it may be so. They have been described as coming from broken homes and they don't get along in this world very well with society, and different things like that, but, on top of that, to get to be an addict they must associate with an addict. If they had all those things wrong with them, if they couldn't get along and everything else, delinquency and the rest of it, if they had never met an addict ten to one they'd never become an addict.

Senator KING: They couldn't be served.

Mr. CRAY: How could they?

Senator KING: They couldn't be served.

Senator LEGER: How many rings would you have in Vancouver?

Mr. CRAY: It is hard to say how many rings are operating at one time, but I would say there is one main ring at the present time and probably other smaller rings.

The CHAIRMAN: Detective, are any of these addicts you come in contact with, do they do any useful work or generally do they live a life of idleness and crime?

Mr. CRAY: Most of the ones we have here have a previous criminal record or a previous delinquency record, although some of them do work at times. Maybe by police pressure or maybe their habit is getting too big for them, they will take a small supply of drugs and go out of town, some logging camp or some isolated district, and when their drugs run out and it is very difficult for them to get back here, they will get off drugs for a time, physically. But in their mind they still have that craving for the drug and when they come back to Vancouver, as they most surely will, if they live in this Province, some time or another they will, in a very short time in my mind, revert to drug addiction. Now, in reference to that, I have known one woman in particular who married a retired man. She was a drug addict of long standing and she married this fellow and he took her out of town and got her off the drug habit. They stayed out of Vancouver for two years. At the end of two years they came to Vancouver on a holiday and of course she stayed here and at the present time she is in Oakalla prison. She reverted to the drug habit after a two year period in which she got away from drugs on her own with the assistance of this man. The same thing applies when you put an addict in jail and he comes out. He is cured physically, he doesn't need the drugs physically, but he still retains his mental craving for drugs which sooner or later will get him back on drugs. Most of them sooner and some of them will try drinking for a while, try going out of town, but the craving is still there and they will come back to Vancouver or some other centre where they can get drugs and revert to the drug habit.

Senator HODGES: Detective, I would like to ask you another question. Do you think that many addicts are created through association with addicts in prisons or penitentiaries?

Mr. CRAY: Well, they may not be created in the prison, (I don't know too much what goes on in the prisons) but surely if they come in contact with addicts in the prisons, you will find that the addicts talk about practically nothing else but drugs all the time they're there and all the time they beat the police officers, and the good feeling they get from this drug. Now, if there are any young offenders in there with them I am most certain that some of them would have that in mind and associate with these addicts when they come out and it wouldn't be very long before they would be addicted themselves. About the addicts talking about drugs most of the time, I know that to be so from my experience. Quite often we have to approach the rooms where addicts are, and listen outside their doors (we don't always break into

the rooms to catch them for drugs because it's the wrong time) and nine times out of ten they are talking about drugs or about some time that they fooled the police about drugs and the good times they had. It all has to do with drugs and drug addiction.

The CHAIRMAN: Senator McKeen, you wanted to ask a question?

Senator McKEEN: I just wanted to know, are the addicts more or less concentrated in one area so that they are close together in the city.

Mr. CRAY: Well, they were at one time but at the present time we have them spread all over the city, although there is a greater concentration of them in the down town area.

The CHAIRMAN: Do they all know each other?

Mr. CRAY: They apparently do. They all—when I see them come down the street, if there are addicts standing on the street they'll all talk to the other addicts. They, apparently, are in one large clique you might say and they all know each other. And if you're not in that clique they don't talk to you very much.

Senator HOWDEN: I want to ask a question. You have been speaking about them coming out of jail after a certain period of incarceration when they were in very favourable physical condition. If they could have been given enjoyable occupation, some pursuit that ran according to their nature, do you think that the temptation to resort to drug would have had the same effect on them? For instance, if their mind could have been taken up with a job which suited or pleased them.

Mr. CRAY: You mean after they came out of jail?

Senator HOWDEN: Yes.

Mr. CRAY: Immediately after they come out?

Senator HOWDEN: Yes.

Mr. CRAY: I still think they would go back on drugs unless they were taken someplace where they couldn't get drugs and more or less kept there. That is you would have to have someone with them to see that they wouldn't come back to Vancouver. I would still say that they would maintain that craving for drugs above this enjoyable pursuit you would present him with.

The CHAIRMAN: Take the instance of a man going to a logging camp and coming back after a year or so, and going right back to drugs.

Mr. CRAY: Yes. It is possible for them to go (especially if they have just gotten out of jail) to a logging camp, or if their parents or relatives get hold of them at that time and see that they get out of town, into a logging camp where there are no drugs (or where they would have to be sent by mail or taken up there by somebody), where the chances of getting drugs are very slight, and his chances of coming to Vancouver are very hard, in other words they might have to come by boat or something like that, they would stay there and they may stay there for a whole year but as soon as they come to Vancouver or some other drug centre, on leave or on holiday, the chances are that they would go back to drugs and they would never get back to that logging camp again.

Senator HOWDEN: You don't think that the horror of being incarcerated and being kept without the drug, that would be a terrible experience I should think.

Mr. CRAY: I have no doubt that it is.

Senator HOWDEN: You wouldn't think that the threat of that recurring experience from time to time would have any effect on their natures?

Mr. CRAY: No, I still think they would have this craving in their minds, this feeling that they get, and they would seek about and—of course they don't figure they're going to get caught again—and they would go back to the drugs above all that. In fact, I've arrested some of them three and four times now but they all keep going back. But I at least think that while they're in jail they aren't starting new addicts and they're being well looked after. They're certainly in a much better condition than when we find them on the streets.

Senator TURGEON: Could you say, please, whether an addict when he is out at a logging camp or some place away from drugs, that his work is just as properly done as if he had not been an addict, after he's there a while and done without drugs?

Mr. CRAY: If he had been there and gotten over his withdrawal and regained his health to some extent I would say it would be possible that his work would be just as good as some of the other men. That is, the work would be as good as he could do—

Senator TURGEON: So, as Dr.—

Mr. CRAY: As long as he was there.

Senator TURGEON: So, as the doctor said, if you could cure his mental desire, his social activity in life would be just as good as it was previously.

Mr. CRAY: If you could get rid of this mental—

Senator TURGEON: Yes, if you could cure that mentally.

Mr. CRAY: If you could cure that, as far as drugs are concerned, I figure he would be all right. Of course some of them have another mental outlook before they become addicts. They have criminal tendencies. You would also have to cure those criminal tendencies.

Senator TURGEON: Before they became drug addicts probably.

Mr. CRAY: Yes. Practically all of them, not all but a lot of them, have these criminal tendencies before they become addicts.

Senator HORNER: Before they became addicts?

Mr. CRAY: Before they became addicts?

Senator HORNER: And they had, in some manner, a warped personality?

Mr. CRAY: I would say in most cases, not all of them, but in most cases there is something missing in their personality. I'm not a doctor, I wouldn't be able to say what that certain thing is, and I wouldn't say it's the same in every case.

Senator HOWDEN: These addicts must be faced from time to time with a terror of not being able to get the drugs.

Mr. CRAY: That is right.

Senator HOWDEN: And I would think that, in order to escape that terror, which is a terror, it would have some effect on restraining them from taking another course in addiction.

Mr. CRAY: I don't think it does. I've seen them sick on the streets, real sick, so that they're vomiting, but they will still revert to the drugs.

Senator HOWDEN: The drug is the very thing that will stop their vomiting.

Mr. CRAY: That's right, sir.

Senator GERSHAW: Mr. Chairman, may I ask if the detective feels that everything possible is being done to prevent the importation of these drugs.

Mr. CRAY: Well, as far as I know, everything is being done but my experiences along that line are limited. My work is done mostly in the City of Vancouver. I am a Vancouver City police officer and we do not very often

get outside Vancouver. We hear a lot about the methods used and how the drug gets here and I know the Mounted Police are doing a very good job on stopping the importation of the drug here, but it is a very difficult job.

Senator HODGES: But it is their function and not yours.

Mr. CRAY: Well, it's ours too when it comes into the city.

Senator HODGES: Yes, but I mean most of the time it lies with them.

Mr. CRAY: Most of that, I would say, lies with the Royal Canadian Mounted Police, because they could conduct an investigation of drugs being brought all across Canada, but when it gets out of the City we can't follow it very much further than that.

Senator STAMBAUGH: Your idea is that it is not very difficult to cure them from the bodily craving but it is almost impossible to cure the mental craving.

Mr. CRAY: Yes. I think it's quite possible to cure them physically. I think any doctor, if he put them into a hospital or a sanatorium, and confined them there could get them off of drugs. But, the point is, he can't keep him off of drugs. The craving is still there and as soon as he's allowed to go on his own again, if somebody isn't with him twenty-four hours a day, he will in time, probably right away, revert to drugs.

Senator STAMBAUGH: And as far as putting them to some useful and happy work, these people are not inclined to work before they become addicts.

Mr. CRAY: That is right. A lot of them were not—in fact I don't suppose a lot of them have done any work before they became addicts. They had criminal tendencies. Although some of them have. I wouldn't say that applies in every case.

Senator STAMBAUGH: We're talking about the majority.

Mr. CRAY: Yes.

The CHAIRMAN: They found it easier to live—

Mr. CRAY: One other thing, if you give them drugs when they're under the influence of drugs, they're too happy to work, they don't want to do any work then. They're feeling fine and I don't think you could persuade them to work at that time. But on the other hand, as soon as the drug wears off they get the sick feeling and they're too sick to work.

Senator HORNER: Do you agree with Superintendent Horton in asking for that amendment to give you the power to arrest and detain them for twenty-four hours or longer?

Mr. CRAY: I think it would certainly help in the apprehension of the peddlers particularly, because they are the ones we see swallowing the drugs all the time. But I do think it would have to go into the hands of experienced drug officers so that the privilege wouldn't be abused. I mean, a person working on narcotic enforcement, with a lot of experience, I don't think he would be bringing in anybody like a good citizen because he made a swallowing motion or something like that.

Senator HORNER: Oh, no.

Mr. CRAY: It has to be done by experienced police officers and a police doctor, or—

Senator HODGES: Under medical supervision.

Mr. CRAY: —medical supervision and not by the police officers.

Senator STAMBAUGH: Have you any doubts but what you have that kind of men?

Mr. CRAY: I don't understand the question.

Senator STAMBAUGH: Well, you say you need these experienced men in order to administer that Act the way you'd like to have it. Have you any doubt in your mind but what you have those men available?

Mr. CRAY: I would say that we have some and it wouldn't take very long for experienced officers to train others. In other words, they wouldn't have to go through all the mistakes I did. I could help them along very quickly in that type of work. I wasn't trained to be a drug enforcement officer. I gained all my experience, you might say, the hard way on the street. And once you get it that way you don't make very many mistakes in that type of work.

Senator STAMBAUGH: You don't seem to forget much of it either.

Mr. CRAY: No, I guess not.

Senator HOWDEN: Your testimony offers us a very dreary picture. I take it that you have no hope of curing this evil in social life at all.

Mr. CRAY: I wouldn't say that. I would say in my opinion there is very little hope for the ones addicted at the present time but if we do the right thing at least the ones that will become addicted in the future we can save them.

Senator HOWDEN: Well, what have you got to offer? As a solution?

Mr. CRAY: Well, you must take the addicts we have at the present time out of circulation so that they won't make any more addicts. If we don't do that we'll have a lot more in ten years from now, or even in a year from now.

Senator HOWDEN: That is your suggestion to this Committee? That we isolate the addicts.

Mr. CRAY: Yes. When you have them isolated you can experiment with them, have doctors see them, and if there is a cure at least you will have less to cure than you will have ten years from now.

Senator HOWDEN: That's fine, thank you. That's your submission and that's what I wanted to know.

Mr. LIEFF: I just want to deal with that last topic a minute. The one about the new type of treatment you want while you're holding a man under arrest—holding him for a day.

Now, you've often laid charges of vagrancy, I suppose, against people who have been suspected of charges?

Mr. CRAY: No. Vagrancy is a charge.

Mr. LIEFF: It is a charge, but you have nothing better for the moment and you want to hold him, so you have laid vagrancy charges in your day, haven't you?

Mr. CRAY: Yes, if I have evidence of a vagrancy charge.

Mr. LIEFF: Well, here you have a man whom you know has within his body some capsules that he has swallowed.

Senator HORNER: You suspect.

Mr. LIEFF: You suspect, yes. What is to prevent you from laying a vagrancy charge and having him sent out to Oakalla and have them do the job there.

Mr. CRAY: Well, if we had grounds for a vagrancy charge he could be sent out there.

Mr. LIEFF: First of all, he's a man who is not working, he has no visible means of support as far as you know—

Mr. CRAY: That's correct in most cases.

Mr. LIEFF: And a vagrancy charge is in order, is it not?

Mr. CRAY: Yes.

Mr. LIEFF: Well, why couldn't you lay that type of charge and have him sent out to Oakalla?

Mr. CRAY: I think it could be laid in a great number of cases.

Senator HORNER: I think it ought to be done.

Senator HOWDEN: How long would it take?

Senator HODGES: I'd like to follow that up. Would a vagrancy charge give you permission to administer the sort of treatment you want?

Mr. LIEFF: If he's on remand then, they can do it at Oakalla can't they?

Mr. CRAY: I don't know what the regulations are at Oakalla. I believe the Superintendent says they can at Oakalla, and if that's possible they could do it, but, you would have the difficulty of keeping him under close observation all the way out there and it may be that the time lapse, unless you got him out there quickly—

Senator HOWDEN: How much time would that process take? I am a doctor and I want to know how much time it would take you to take a man out to Oakalla, wherever that is, from the time you arrest him.

Senator STAMBAUGH: You would have to lay the vagrancy charge and get that over with.

Senator HOWDEN: Just a minute, just a minute—

Senator STAMBAUGH: Well, that's all in the time lag. Let's get it all.

Senator HOWDEN: I want to know how much time it would take to get the man there from the time they arrest him.

Senator STAMBAUGH: Well, that's what I want to know.

Mr. CRAY: Well, if he didn't have to appear on the charge, and the charge was laid right away and arrangements made to take him out there immediately, I imagine he could be gotten out there in an hour, if arrangements were made ahead of time so that you could get him out there quick.

Senator HOWDEN: That's fine. This capsule would probably be resistant enough of the acids of the stomach to remain a capsule—

Mr. CRAY: Yes.

Mr. LIEFF: Well, it would be wrapped anyway.

Senator HOWDEN: It would be wrapped. If it were an ordinary capsule such as we put medicinal substances in it would be dissolved?

Mr. LIEFF: But it's in a rubber container that would not be dissolved for hours, for days, and silver wouldn't be dissolved.

Mr. CRAY: No, in fact it will pass right through the body and the addicts will look for it.

Senator HOWDEN: That's a very important point.

Senator BEAUBIEN: Mr. Chairman, may I be permitted to ask a question?

The CHAIRMAN: Yes, Senator Beaubien.

Senator BEAUBIEN: I understand from your brief and the explanations you have given, that there is no cure for the addict?

Mr. CRAY: Would you repeat that, sir?

Senator BEAUBIEN: Do I understand, through your submission, and the explanations which you have given, that there is no cure for addicts. It's always in his mind and when he gets within reach of it he goes back to it, am I right?

Mr. CRAY: Yes. In my opinion there is no permanent cure. In other words, they can be gotten off drugs by doctors but you can't keep them off, that is what I say.

Senator BEAUBIEN: Then, the only cure for the addict is to isolate him someplace where he can't reach narcotics, is that correct?

Mr. CRAY: That is correct.

Senator BEAUBIEN: Now, would you have to keep that man isolated for the rest of his life?

Mr. CRAY: Well, I would think so. But, if you have him there where he can be observed by doctors and special treatment given him, it may be that he could be, at some future time you could take a chance on him and parole him. And then if he—

The CHAIRMAN: If he broke the parole.

Mr. CRAY: —if he broke the parole you could put him back in and that would be it. I think he should be given a chance after he's been there. But in my opinion I think it would be a long chance as far as that goes. It may be possible after a great many years, with special treatment, maybe the doctors, the medical profession, will come up with a cure.

Senator HORNER: I think that even though you are in the right to arrest on vagrancy and take them out to Oakalla, and also include this amendment, that even if a good citizen, he shouldn't take serious objection. The matter is serious enough. Even providing he is innocent and goes through this process, if it gives you a chance to catch the guilty, I think you should do it whether it's to Oakalla or whether you have an amendment here.

Mr. CRAY: That's quite true, but if by chance we did get a legitimate citizen, he would object, there's no doubt about that.

Senator HODGES: They have the blood test for alcoholism.

Senator HORNER: Many things good citizens have to put up with.

Mr. CRAY: But I'm stating that if you had experienced officers—in other words, when I'm on the enforcement of drugs, when I'm walking down the street and I grab a man (that put something in his mouth) by the throat and wrestle with him in an attempt to get it, I am very sure that he is not a private citizen before I do that. I know that he is an addict or a peddler from my observations and experience and in order to get that evidence the Act says you can use as much force as is necessary. And to get drugs out of a man's mouth takes a lot of force.

Mr. CRAY: We have done it although it's not the usual way in which I go about it.

Senator STAMBAUGH: Have you ever missed yet?

Mr. CRAY: Yes. I nearly lost the end of my thumb once doing it, but anyway—

Senator STAMBAUGH: I mean did you ever get an innocent citizen and do that to him?

Mr. CRAY: No, I never have.

Mr. LIEFF: When taking statements from a witness the law protects a witness in such a way that you can't use any statement that he will not make voluntarily, is that right?

Mr. CRAY: That is correct.

Mr. LIEFF: So that while the law protects a witness against having to talk, you're suggesting now that we go farther than that and examine and clean out the inside of his stomach, involuntarily, is that right?

Senator STAMBAUGH: Well, that's more direct than talking, anyway.

Mr. CRAY: The suggestion is that it would be a lot of assistance in apprehending—

Mr. LIEFF: Oh, I don't blame a police officer for wanting that power, but you can't force him to talk, can you?

Mr. CRAY: No.

Mr. LIEFF: No, but still you want to force him to divulge the inside of his stomach.

Mr. CRAY: Well, he has the evidence there—

Mr. LIEFF: He'd have the evidence in his mind if he wanted to confess something to you, wouldn't he?

Mr. CRAY: But you can't get it from his mind by any means.

Mr. LIEFF: Even if he did give it to you after some slick questioning, you can't use it unless you warn him and all that sort of thing.

Mr. CRAY: You still couldn't use it if you asked him a lot of questions after the warning.

Senator HORNER: I think, Mr. Lieff, it is somewhat different in talking and if you feel positive this man has swallowed a capsule and has this in person. I think it's a little different than forcing a witness to talk.

Mr. LIEFF: I'm afraid the lawyers and police would have to disagree on that one.

The CHAIRMAN: I wonder if Inspector Mead would care to say a word or two.

Mr. MEAD: The only thing I would like to say is that I believe our whole submission boils down to this. That is, that the important thing to our way of speaking or thinking is prevention rather than wasting our resources, or possibly not wasting but directing our resources towards rehabilitating the present addicts. You have had many medical men here talking to you and I don't think that one of them said that it is an easy thing to cure an addict. Now, of those that I heard (and I didn't hear them all) I didn't hear any of them mention prevention. I think prevention is our best hope of making any permanent progress.

Senator STAMBAUGH: Very good.

Senator HOWDEN: Well, if we can't cure these addicts what are we going to do with them. We come back to the old question again.

Mr. MEAD: If we can't cure them, let's write them off.

Senator HOWDEN: You're not thinking of killing them or anything of that kind?

Senator STAMBAUGH: Lock them up the same as we do insane people.

Senator HOWDEN: You can't lock them up. You can isolate them, incarcerate them.

Mr. MEAD: That's what we suggest.

Senator HOWDEN: That's fine.

Senator HORNER: You've made a good case too.

The CHAIRMAN: Any other questions? If not, we stand adjourned until two o'clock.

Senator HODGES: I think we should thank the detectives.

The CHAIRMAN: Yes, thank you very much.

May we have order in the Court. Yes, Superintendent?

Mr. HORTON: Mr. Chairman, if the members of this Committee have that view which I suggested, would you notify the press not to publish it because we don't want the press trailing us all around and having it in the papers or the individuals we are going to see are not going to be there. There is no use taking you out to view—

The CHAIRMAN: That is one of the matters I want to discuss with the members of the Committee, very much, because I realize the press—

Senator HOWDEN: Notify the press now.

Mr. HORTON: Not to make any mention that we are going to have a view.

The CHAIRMAN: In the interest of the Committee we think it would be advisable not to publish that.

The Committee adjourned until 2:00 this afternoon.

AFTERNOON SITTING

WEDNESDAY, April 20, 1955.

The Committee met at 2:00 p.m.

The CHAIRMAN: Gentlemen, we will start the afternoon proceedings. The first witness, because he will have to get away, will be Dr. George Elliott, Assistant Deputy Minister, B.C. Department of Health. Dr. Elliott will you please come forward. May I welcome you, sir, on behalf of our Committee.

Dr. ELLIOTT: Thank you. Honourable Senators, this brief is presented by the Health Branch and is over the signature of Dr. Amyot, Deputy Minister of Health of this Province. It is brief and I think much of this material perhaps you have already covered. The Health Branch, the Department of Health and Welfare, the Province of British Columbia, recognizes that the problem of drug addiction is of a wide degree of interest to a number of official agencies, in the welfare, legal, religious, law enforcement, financial and health fields—

The CHAIRMAN: Doctor, would you mind just raising your voice, if you don't mind?

Dr. ELLIOTT: The Health Branch, etc.,—on a local, Provincial and Federal level. While these interests overlap and interlock with one another, public health must concern itself with the effect of drug addiction, direct and indirect, upon the general health pattern of the Province.

It is recognized that these effects are concentrated mainly within one section of the Province and mainly upon one section of the Community. The direct effects reflect themselves in the generally lowered well-being of the addicts and their families with whom a general decreased living standard engenders a constant lowering of health standards, physical and emotional. Indirectly the presence of a sizable group of drug addicts promotes an increased potential community health hazard. Most prominent is the venereal disease potential harboured among the female addicts who resort to prostitution to support their addiction. But it must be admitted other diseased conditions, such as tuberculosis may spread by addict cases who may avoid treatment of their illness.

The Health Branch finds that drug addiction must be classified as a disease amenable to treatment. The degree of treatment must vary upon a number of factors, such as,

1. The depth of the individual addiction—
2. The history of criminality—
3. The emotional stability of the patient—
4. The age, sex and marital status—
5. The reaction of the patient to treatment measures.

Treatment should be directed towards the attainment of absolute individual addiction control and complete rehabilitation of the patient. Based upon these concepts, the general recommendations which this Health Branch would make towards this goal would be:

1. Establishment of an in-patient treatment clinic to which admission should be on the voluntary or committal basis, but no discharge possible under a minimum period to be determined. This hospital should have maximum security; all visiting being forbidden; staff should be carefully selected from competent positions and the allied professional groups in the various specialties concerned.

2. Development of an institution providing treatment facilities for addicts requiring long-term steady treatment. Admission to this hospital should be selected from:

- (a) Cases which have lapsed into addiction following previous treatment;
- (b) Addicts who refuse to cooperate in treatment in the clinic, and
- (c) For addicts who cannot be successfully treated in the clinic.

Handling of the inmates of this hospital will involve a combination of custodial care plus treatment plus rehabilitation, on a long-term basis. The same degree of security and careful selection of staff would apply to this hospital as in the in-patient clinic. To transfer to this institution of addicted prisoners committed for major crimes should be avoided at the on-set of this hospital, or at least until treatment pattern procedures have developed to a measurable successful degree.

3. The Health Branch would recommend that the handling of the addict in either the in-patient clinic or the long-stay hospital should be coupled with a complete rehabilitation program into which occupational and vocational therapy would occupy a major role, if the patient is to be returned to the community as a usual productive member of society.

4. Research under the direction of competent researchers should be encouraged, intensified, as it is at the present time. There is a definite need for more information of the cause of the process of addiction and its ultimate control.

5. Municipal, provincial and federal governments should pool their efforts and resources towards the development of an effective treatment program.

This is respectfully submitted by the Health Branch.

Mr. LIEFF: I wonder if you would permit just one question, to clarify a small matter. I think you suggested at the very beginning that the in-take policy should be based on either voluntary or—. I wonder if you would deal with that again just so that I may make sure that I know what you said. You talked about committal by agency, or on a voluntary—

Dr. ELLIOTT: It should be on a voluntary committal basis.

Mr. LIEFF: Now, here's what I wish you could help us with. Literature on Lexington, for instance, has indicated the difficulty about the patients who go in by themselves, because they want to leave and they get out. Now, would you mean that a person could come forward and say I want to be committed, and once there you would keep him as long as necessary.

Dr. ELLIOTT: That is correct. The next sentence covers that.

Mr. LIEFF: That clears it up.

Dr. ELLIOTT: Note that we had in here at one time that no discharge should be possible under a period of six months but we left there "a minimum period to be determined".

Senator GERSHAW: In either case.

Dr. ELLIOTT: That is correct, sir. In either case he stays there as long as he is required.

Senator STAMBAUGH: Whether it's voluntary or committal.

Dr. ELLIOTT: Yes, sir.

Senator HODGES: I'd like to ask, Dr. Elliott, these in-patient departments, is it proposed to make them part of the general hospital system or to have an entirely separate institution for the in-patients.

Dr. ELLIOTT: I think it would be a separate hospital.

Senator HODGES: Oh, yes. Not to work in under the present system.

Senator TURGEON: Nor would you accept addicts in the hospital, is that correct?

Dr. ELLIOTT: That is correct.

The CHAIRMAN: Any other questions, senators?

If not, doctor, we appreciate very much your having come today.

Warden Douglass, on behalf of the Committee, I bid you welcome.

Warden DOUGLASS: Thank you. You have copies of my brief?

The CHAIRMAN: Yes. You may sit down, Warden.

Mr. DOUGLASS: Mr. Chairman and members of the Committee, I have been invited here to appear before this distinguished committee as Warden of the British Columbia Penitentiary, in connection with the drug addicts that are serving a sentence in prison. If I may, I would like to read to you a short summary of my statistical report which you have before you. (*See Appendix J.*)

At the present time there are 161 drug addicts serving sentences at this penitentiary, and 505 inmates who are not drug addicts, making a total prison population of 663.

If we go back to 1948, seven years ago, there were exactly 61 drug addicts in the penitentiary. There has been a steady yearly increase since 1948 until today the total of 161 has been reached.

The percentage of drug addicts in the penitentiary with a total prison population of 663 inmates is 24.35%.

The average age of a drug addict is 34 years, while the average age of other penitentiary inmates is about 33 years. The youngest drug addict is eighteen years of age, and the oldest sixty-seven.

Educational standing, table 6, page 2, shows the educational standing of the 161 drug addicts. 129 of them have attained grade eight or higher in educational standing, or in percentages 80% have at least grade eight standing.

Table 7, page 2, shows the offences for which the 161 drug addicts are presently serving sentences in the penitentiary. This discloses that 133 of them are serving sentences for drug offences and 28 for non-drug offences. In percentages 82% are serving time for drug offences.

Analysis of the 161 addicts as shown in table 8, page 3, shows that 111 are of Canadian racial origins—that is British and French. Of these 111 addicts 101 were born in Canada, while ten were born in the British Isles and had been in Canada five years prior to 1947 for the purpose of permanent residence here. The remaining 50 addicts are of various foreign racial origin as shown on table 8 (a), page 3. It is to be noted, however, that although 50 are of foreign racial origin 46 of them are Canadian citizens, having been

born in Canada. Only four are foreigners having been born abroad. In percentages, therefore, 69% of the drug addicts here are of Canadian, British and French origin, and 31% are of foreign origin.

Criminal history, table 9, page 4, shows how many previous penitentiary sentences these drug addicts have served. It will be noted that 65.2% have had previous penitentiary sentences and 24.8 have had no previous sentences.

Senator HODGES: Is it 24 or 34?

Mr. DOUGLASS: 34.8%. Although 56 have had no previous penitentiary sentences table 11 and 11 (a) on page 5, shows that there are only six first offenders. All the rest of the 161 addicts having had either penitentiary or jail, or reformatory, sentences, or a combination of them. There are only six first offenders, with no previous criminal record. Table 11 (a), page 5, shows that of the six first offenders three were sentenced for distribution of drugs and three for possession. Their ages vary from twenty-two to thirty-four years.

Prison behavior, table 12, page 5, shows 37 of the drug addicts have been charged with prison offences which represents 23 per cent of the drug addicts population of 161. Comparing this with the 505 inmates who are non-drug addicts, we find that 127 of the non-drug addicts have been charged with prison offences which represents 25.3 per cent of the non-drug addicts population. These figures would tend to show that the drug addicts are less troublesome in prison than the non-drug addicts.

Table 10, page 4, shows that 181 addicts have had 377 convictions on drug charges and in addition 980 convictions on non-drug charges, making a total of 1,357 sentences, including jails, penitentiaries, reformatories imposed on them. This represents a total of 8.4 sentences per drug addict as an average and would tend to confirm that drug addicts are frequently in conflict with the law.

Physical and mental condition of inmate drug addicts. The penitentiary physician has reported to me that those drug addicts who have been taking large quantities of drugs daily, for example fifteen to twenty caps are underweight as much as fifteen or twenty pounds on reception to the penitentiary. Mentally the condition of inmates who are drug addicts is no different from other inmates. The majority of them are cooperative, both on reception at the penitentiary and during their incarceration.

As regards treatment in the penitentiary, the penitentiary psychiatrist "conducts group therapy among a selected number of drug addicts". There is such a group of 14 undergoing this therapy at present. The object is to make the inmates under very informal conditions discuss their problems amongst themselves and by doing so they become more aware of their condition and the reason for their desire for drugs and thus, on discharge from the penitentiary, are more likely to make an honest effort to keep away from the use of drugs. There is no actual medical treatment for drug addicts.

I'll continue quoting from our psychiatrist.

The CHAIRMAN: What page are you reading?

Mr. DOUGLASS: That's four, but I doubt whether it's on there, Senator.

Our penitentiary psychiatrist states that treatment centres should be established in all the major cities in Canada for the purpose of determining the old addicts from the new, and establishing who should receive free treatment and those who should not. A thorough search should be made in all cases before any conclusion is reached to dispense free drugs. The only medical treatment considered to be of use for drug addicts is the withdrawal treatment where drugs or other medicines are given in diminishing quantities to counteract the nervous reaction, etc.

I have noted that during group therapy meetings among the addicts that all they are prone to discuss is the free injections. I therefore do not see any use to continue group therapy with such a group.

At present we are including the old addicts in other group therapy meetings. The "odd" old addicts I should have said. From a psychiatry point of view only a small number of addicts would benefit from psychiatry-therapy. I would go on record and say that the majority of the addicts are satisfied with their way of life and do not wish to be helped or cured. There are only a few that could benefit from counselling psychiatry treatment. The majority of them here have been in anti-social behavior before becoming addicted to drugs.

Young men who are addicts and who want to get off drugs could possibly be helped and a small percentage cured. We could work on this small group but the older confirmed addict is beyond free treatment and will not benefit from it. With this small percentage of young addicts a thorough follow-up program of treatment should be followed."

Trade Training and Rehabilitation, table 13, page 6. Most of the addicts are anxious to learn a trade in the penitentiary, during their incarceration. The following are the totals learning trades in the categories shown:

Blacksmith shop	10
Carpenter shop	4
Canvas working	3
Engineer's dept.	7
Garage	1
Kitchen	13
Laundry	18
Machine shop	4
Mason's dept.	9
Paint shop	3
Shoe shop	5
Tailor shop	22
Tinsmith	2
Vocational carpenters	2
Vocational drafting	1
Construction	3
Farm and Gardening	10
Total	117

In percentages 70 per cent of the drug addicts are learning trades and I would like to refer you to the final section of my report which contains an interview with ten inmates of the penitentiary who are drug addicts.

I trust that my observations will give you a better idea of how drug addicts live and behave in the penitentiary and how they are treated. I would like to add that many drug addicts are good athletes, participating in games such as boxing, football, soccer, softball, weight lifting, field and track sports. During the evening in their leisure hours many of them are pursuing beneficial and productive hobbies and I am of the opinion that taking into consideration the statistic tables of these addicts that their sentences—serving time in the penitentiary—whether for a short period or a long period does not prevent a man from returning to drug addiction upon his release. It is my opinion that the only possible solution to the drug problem is to establish treatment clinics in all the Provinces throughout Canada to dispense drugs to the confirmed addict at a cost, after a thorough screening process has been carried out. This will definitely eliminate the profit for drug peddlers and distributors.

Anyone caught distributing drugs, or peddling, once these clinics have been established, and addicts registered, should be liable to a minimum sentence of life imprisonment.

The CHAIRMAN: Minimum?

Dr. DOUGLASS: Maximum, pardon me.

Senator KING: Your psychiatrist's views, do we have that?

Mr. DOUGLASS: Yes, we discussed it this morning.

The CHAIRMAN: But we have it for the Committee? You were quoting.

Mr. DOUGLASS: Yes.

Mr. LIEFF: Mr. Douglass, I wonder if we could just discuss for a few minutes the proposition that you just made of providing drugs at cost to confirmed, older addicts. Did you say "confirmed, older addicts?"

Mr. DOUGLASS: Yes.

Mr. LIEFF: Would you make it conditional upon them working, or being useful in some way?

Mr. DOUGLASS: Oh, yes, that would naturally enter into the after care of the rehabilitation.

Mr. LIEFF: Do you think that these older addicts, given a choice of taking treatment, would take it at their stage in life?

Mr. DOUGLASS: Definitely. They would be very glad to take drugs, I mean if it was—

Mr. LIEFF: Oh, yes, I know they would take drugs, but if you're just going to give them the drugs—

Mr. DOUGLASS: No, they're not interested in treatment.

Mr. LIEFF: They're not interested in treatment.

Mr. DOUGLASS: No.

Mr. LIEFF: So you are providing them, in your proposition, with free drugs.

Mr. DOUGLASS: Yes.

Mr. LIEFF: And that I suppose, would be the aim of the younger addict as well, he will be able to get all he wants as soon as he gets old enough, is that it?

Mr. DOUGLASS: No, what I mean there, they have to be properly screened by the Committee of the clinic. I mean the professional people in the clinic and they will decide who is going to get drugs at cost—I don't think they should get drugs free—possibly they should pay for it—

Mr. LIEFF: We'd make it easy for them anyway.

Mr. DOUGLASS: Yes, to a certain extent.

Senator HORNER: You would make it legal at least.

Mr. DOUGLASS: That is right.

Senator STAMBAUGH: How would they pay for them if they won't work.

Mr. DOUGLASS: You mean that they are all parasites that are not going to work?

Senator STAMBAUGH: Well, you said that they don't want to work. They don't want to quit drugs.

Mr. DOUGLASS: They don't want to quit drugs but I'm not saying that they don't want to work.

Senator STAMBAUGH: You think that even if you give them drugs they'll want to work?

Mr. DOUGLASS: I would think that a man around twenty-five or thirty years of age, if he can get drugs, if he's a drug addict, a confirmed drug addict that medical science has decided that he's a drug addict, and we have decided that

there is nothing we can do for him, we can't treat him, we can't cure him, then I would think they could hold down a job at a reasonable salary and they could at least pay a minimum price for drugs, where today they just simply can't buy them at the cost they're selling them on the streets for.

Mr. LIEFF: Warden, if they just won't work though, and they haven't any money, would you put them on social security.

Mr. DOUGLASS: If they don't work, they are unable to buy drugs and they may commit a crime.

Mr. LIEFF: So they go back to the criminal element again. So you say they would wash themselves out of this legal group and go back to the criminal element?

Mr. DOUGLASS: Yes.

Senator HODGES: Warden, I would like to ask a question. These views you are expressing as to the method of dealing with them, are they also your own opinions? They seem to conform to opinions which you discovered in an interview with addicts who seem to hold the same view.

Mr. DOUGLASS: You mean in that last—

Senator HODGES: In that last.

Mr. DOUGLASS: I haven't discussed that, but I am just giving you that as coming from a group of ten drug addicts.

Senator HODGES: I know, but a lot of the views they have expressed would seem to have the same basis as you are opinion—

Mr. DOUGLASS: That's possible.

Senator HODGES: But the views you are expressing are your own views, not the views of these addicts?

Mr. DOUGLASS: No. They're my own.

Senator HODGES: Because it's natural that an addict would suggest he get free drugs, and have access to more drugs.

Mr. DOUGLASS: Well, if there's no cure for them.

Senator STAMBAUGH: You think there is no cure?

Mr. DOUGLASS: I don't think there is a cure for them. But there are a number of young men who are using drugs that I would give up hope, I would say that possibly science or medical treatment will be able to do something for them. But I think with these clinics we'll find out more about drug addicts. What causes them to be drug addicts.

The CHAIRMAN: Warden, in view of the fact that these men are incarcerated and your view is to keep them employed in the penitentiary and not cure them, on what grounds would you say they are incurable? Your duty is somewhat similar to that of the Warden of Oakalla; you keep them in prison but no attempt is made to cure them, you give them useful employment and they are fed and sheltered and guarded. Now, they claim to us that there is a difference between that kind of treatment and setting out to cure them. That they are being kept against their will and that the desire of these men to get out is to simply get more drugs.

Mr. DOUGLASS: Yes.

The CHAIRMAN: So therefore, the evidence has been presented to us (I have formed a personal view) but how do you know they are incurable?

Mr. DOUGLASS: Incurable?

The CHAIRMAN: Yes.

Mr. DOUGLASS: Well, we've had men return to the institution fourteen times, twenty-seven times. They started to use drugs, to smoke opium—one man in 1913—and he's had about twenty-four convictions for drugs. He's

sixty-seven years of age today. We have had others who go back thirty years. They've been convicted of drugs and they're in the penitentiary. I don't believe that the confirmed or chronic addict can be cured. I don't think he wants to be cured.

Senator HODGES: This man that you're speaking of, has he ever undergone the treatment?

Mr. DOUGLASS: They haven't been able to find a treatment or set-up to keep him away from drugs. You might say they go through treatment when they go into an institution for three years to five years. There's no drugs in there.

Senator HORNER: They don't get any drugs?

Mr. DOUGLASS: They don't get any drugs, definitely there are no drugs. They're in good health, the majority of them are bright and intelligent.

The CHAIRMAN: Do you segregate them from the others?

Mr. DOUGLASS: No, we don't segregate them. I think possibly segregation in an institution is a step in the right direction—

The CHAIRMAN: The reason I ask that is because there is a feeling among some that mixing them spreads the idea of drugs among those who are not drug addicts. They tell us that in Oakalla they're segregating them now. They segregate all the drug addicts by themselves in a group and treat them a little differently.

Senator TURGEON: Warden, have you reached any conclusion as to the length of time a person has taken drugs before he becomes chronic and so-called incurable?

Mr. DOUGLASS: That is a very difficult question to answer. I think it usually takes a few years—two years possibly.

Senator TURGEON: If you get them still young before they have gone a couple of years, there is still a chance?

Mr. DOUGLASS: Yes, I think with the proper set-up with treatment. We know very little about drugs and I don't know of anyone that can come out and say this is the way they should be treated. We're all just hit and miss in this business. We're trying to rehabilitate them when they come out. We're teaching them trades when they're confined and a lot of them are good tradesmen. As you see, there are a great majority of the ones we have in prison, are learning something about a trade. They can't become, possibly, efficient in that particular trade in the short time they are going to be with us but they know enough about it where they could, if they wanted to, they could hold down a job.

Senator TURGEON: You feel that regardless of how much they have been able and willing to learn a trade if they've been a long period taking drugs they still would take it again once they get a chance outside, after a couple of years speaking roughly.

Mr. DOUGLASS: That's my opinion.

Mr. LIEFF: Just as a matter of filling in, how about the other 30 per cent who are not learning trades, how are they occupied.

Mr. DOUGLASS: Well, they do various kinds of work around the institution. They lack interest in a trade.

Mr. LIEFF: They're not interested so you just give them other jobs to do.

Mr. DOUGLASS: Menial work around there, yes.

The CHAIRMAN: Tell me warden, in the number of inmates in the past few years, is the age going down, younger. Are you getting younger addicts than in the past years? Are the youthful drug addicts increasing?

Mr. DOUGLASS: I wouldn't say. I haven't got statistics on that. I think it's about average. There are some, we have one who is eighteen, of course, that's just a rare case.

The CHAIRMAN: Would you tell the committee, when these particularly young ones are released at the gate, free, who meets them, their cronies or do their families meet them?

Mr. DOUGLASS: Well, those who have relatives, they meet them and some of them have friends who could possibly be an ex-convict. But those who have homes why their relatives meet them and take them home.

Senator HODGES: Your interest in them ceases the moment they leave the penitentiary.

Mr. DOUGLASS: Yes, we—

Senator HODGES: There's no follow-up care?

Mr. DOUGLASS: Well, we turn them over to the John Howard Society or the National Employment Service. They interview them in the prison before they are released and they try and place them in various work in the city of Vancouver, or wherever they are near their home. Of course, we don't have any agents for following them up that are paid by the Dominion Government. But they have a lot of social workers in the field and there is the John Howard Society and of course our classification staff, they are in contact with agencies in Vancouver and are looked after that way. The opportunity is there if they wish to take advantage of it.

The CHAIRMAN: When you receive these prisoners I presume you receive most of them from Oakalla and by that time they would be off drugs, is that right?

Mr. DOUGLASS: That's true. We have no problem so far as withdrawal is concerned. We don't treat them at all.

Senator STAMBAUGH: I believe you stated, warden, that your youngest inmate was eighteen. They wouldn't be committed to your prison under eighteen, would they?

Mr. DOUGLASS: That is a case where we have a drug addict who is—pardon me, he is not a drug addict. That is, he's sentenced for distributing drugs.

Senator STAMBAUGH: But do you have people committed under eighteen years of age, in your prison?

Mr. DOUGLASS: Yes.

Senator STAMBAUGH: Oh, you do. I thought they were all over eighteen.

Mr. DOUGLASS: No.

Mr. LIEFF: Are they segregated?

Mr. DOUGLASS: They are known as young inmates under twenty-one years of age, and they are segregated as far as their sleeping quarters are concerned, but you just can't segregate a lot of people, a lot of inmates in one institution. You would have to have separate institutions.

Mr. LIEFF: You haven't got a college base set-up or anything like that?

Mr. DOUGLASS: No. I often wish we had though.

Senator HODGES: Warden, I'd like to ask you another thing. I see that you have drawn a conclusion that the drug addicts are less troublesome in prison than the non-drug addict population. We have been given to understand from various witnesses, that the drug addict is most troublesome in the community when they can't get the drugs. Apparently you don't have that experience in jail?

Mr. DOUGLASS: No, we don't have any trouble like that at all.

Senator STAMBAUGH: But they have had their withdrawal before they get there.

Senator HODGES: Oh, I know, I know, but it's an interesting point to notice that the proportion of them that cause trouble is so small compared to the others.

Mr. DOUGLASS: It is, and we find that they are very good athletes too.

Senator STAMBAUGH: It is an interesting point.

Senator HODGES: That's another thing you see which seems to be at variance with some of the views expressed, that drug addicts are diseased, and that their health is menaced to such an extent that you can't think of them as good athletes. Are you speaking of drug addicts who are comparatively recent addicts?

Mr. DOUGLASS: No. If they take large doses on the outside—ten to fifteen capsules, or something like that—they'll be under weight when they come in. But if they're not a heavy drug addict, we see no difference as far as their physical body is concerned according to our doctor.

Mr. LIEFF: You build them up some, don't you?

Mr. DOUGLASS: Sure, they get good food and they soon put on extra weight. They have regular retiring hours, etc.

The CHAIRMAN: Any other questions by the honourable senators? If not, Warden Douglass we appreciate very much your being here.

Dr. Davidson, I understand you want to get away for an appointment, so we will place you as our next witness.

Dr. Davidson is the Assistant Director of the B.C. Mental Health Services.

Senator HODGES: Have you copies of your brief, doctor?

Dr. DAVIDSON: I'm sorry I wasn't prepared to hand out copies for everyone, so I only have my own copy with me. I'll just read it. I am presenting this statement as a representative of the British Columbia Mental Health Services. My experience with drug addiction has been limited primarily to those addicts where committal to the Provincial Mental Hospital has been necessitated due to the development of psychotic symptoms.

The policy of the Mental Hospital in British Columbia excludes the admission of drug addicts unless they are suffering from a psychosis or a frank mental illness. This policy has been in effect since 1921. For a period in 1920 and 21, drug addicts were admitted to the Mental Hospital but this policy had to be reversed because of the many difficulties arising from their presence. In 1952 I was one of a group of three sent by the Provincial Government to study the setup at the United States Public Health Service Hospital at Lexington, Kentucky. We also, at that time, had the opportunity of studying the projective setup of the hospital for treating adolescent addicts at River Side Hospital in New York City. A report on these observations was made to the Attorney General of the Province at that time. So, therefore, actually, my experience is limited and I cannot qualify in any way as an authority on the drug addiction problem, but nevertheless I am interested in it as a problem in the community in particular.

The problem of drug addiction is extremely complex and difficult and I think this has to be stressed. The causes of addiction involves personality problems which are severe and an organized international drug ring designed for the promotion of this type of problem. The solution of this problem is bound to be difficult, but certainly should not be deferred because it appears so imposing and so impossible. I do not want to needlessly go over a lot of facts pertaining to drug addiction which I am sure have already been discussed by others more capable of doing so. However, there are several observations that I would like to make.

In considering the problem of drug addiction it would seem that it is necessary to consider two aspects of the problem. First, the problem of the individual drug addict and secondly, the over-all problem of drug addiction in the community. Concerning the individual drug addict, I think that it is quite obvious that some active treatment program is desirable for these individuals so involved. Certainly these individuals who have a real sincere desire to break the habit (and there are some) should have access to some humane form of treatment to assist them in this very difficult procedure. Unfortunately, today there is no adequate place where such an individual can obtain that treatment. Also, those who are apprehended and found to be suffering from this habit, but who are not so well motivated in their desire to break it, these should also have all the possible help in this regard that we can possibly offer.

This treatment will involve a great deal more than actual physical withdrawal of the individuals from the drugs. Some would have you believe that this is all that is implied in the treatment program, but I assure you that there is much more that can be offered. Treatment will also consist of attempts at dealing with the personality problems of the individual with a view to altering their outlook and their attitudes. These may be accomplished by psychiatric or a social program which certainly should be provided.

One of the characteristics of drug addiction is the extreme ease with which they return to the use of drugs immediately after they have been entirely freed of their habit. It is impossible to understand how these individuals, so much better in mental and physical health and in economic possibilities, can return with such ease to the use of these drugs. The possibility of an individual not reverting to the habit will be definitely increased in some instances by a well organized rehabilitation program.

The objective of any treatment program should be to return the addict to a position of self-support and self-respect in the community. This cannot be accomplished unless there is adequate supervision—the post-release treatment. Unless we are prepared to recognize that the dischargée has basic, dependent needs and are prepared to meet these needs and assist the individual to satisfy them, the possibility is that the subject will have no alternative but to resort to the use of drugs as a substitute. In spite of any active treatment and rehabilitation program the percentage of cures is bound to be disappointingly low. This has been found in Lexington where they estimate their results variously from ten to twenty percent that they consider cured. The remainder, which is a large group of individuals, are not relieved by the treatment program which they have to offer at Lexington. One must be prepared then for such disappointments in dealing with this vast problem of drug addiction.

This is the serious aspect of drug addiction as far as a problem in the community is concerned. What to do with this large group of incurable addicts? The matter is made more serious because of the apparent infectious nature of drug addiction. Individuals who are addicts tend to encourage addiction in some of those with whom they come in contact.

An adequate program then will provide active therapy and rehabilitation for all drug addicts who might benefit from such a program. It would seem also that in some way it should provide for more prolonged segregation for those chronic individuals who are found that cannot benefit from the above program.

In the River Side Hospital project, juveniles found to be addicted are sentenced to an indefinite period of not more than three years. This permits of some control to be kept over these individuals during the treatment period and also during the period of rehabilitation. Those who are found to have

reverted to their addiction after leaving hospital can then be returned to custody. It would seem that some legal control over the individual is necessary, after he is discharged from hospital. This would mean evolving some legal machinery to enable the committal and custody of the addicted individual.

The cost of such care for an entire program wouldn't necessarily be very high. At Lexington, in 1952, the per capita per day cost was \$7.00 per day and this was for a very large population.

The CHAIRMAN: Per patient?

Dr. DAVIDSON: Per patient daily. At River Side Hospital, New York, for 150 patients the estimated annual expenditure was \$1 million dollars a year. Against this, according to the Community Chest survey in 1952, drug addiction in 1952 was supposed to cost the city of Vancouver, in the neighborhood of \$10 million dollars. I realize that this figure has been contradicted but that was the figure that the Community Chest arrived at. This largely because of the volume of crime initiation by drug addiction. In Canada it was estimated that this involved a sum of at least 30 million dollars. Certainly a fairly healthy program of drug addiction control could be supported with this sum of money, and even with a much smaller sum of money than that large figure.

In considering this type of program it would seem to me to be necessary to have a complete and comprehensive program in order to obtain the most satisfactory results. If this program is to be effective it is to be preferred that it be an all-out-effort. Any piecemeal attack, such as only establishing treatment centres, to my way of thinking is bound to be ineffective in dealing with the entire problem.

Another aspect of drug addiction to be borne in mind is the wide incidence of the problem throughout the Continent. It would also then seem desirable to have a uniform program of attack in all areas concerned. Otherwise, we will have movement of addict population from one centre of the country to another, depending upon the different types of programs in effect in these different areas.

The problem of the type of institution where the addict should be treated and segregated deserves attention. It has generally been found (and this is information obtained from the authorities at Lexington) that addicts are rejected by inmates and staff of both mental hospitals and jails. This is not good for the addict and it is definitely detrimental to the active program of care for those in these institutions. It is felt then that addicts should be treated in specially designed institutions, designed to meet their specific problems. These are maximum security, which is necessary particularly to prevent the passage of contraband back and forth from the outside, and secondly, medical and psychiatric care and evaluation. This institution for the treatment of drug addiction should be provided with all the necessary facilities for these departments.

These are my thoughts in regard to the over-all medical program of the care of addicts and the addict population. It is recognized, however, that institutional care is only one aspect of the problem of drug addiction. To meet this problem adequately efforts in the field of law enforcement, and community education will certainly play an important role. The three together holds the only promise, in my mind, of controlling the problem of drug addiction.

Mr. LIEFF: Doctor, would you permit a question or two? The River Side set-up has been considered by those who are in the field as more in the nature of an experiment, is that not right?

Dr. DAVIDSON: Yes.

Mr. LIEFF: And would you apply that to Lexington as well?

Dr. DAVIDSON: I think that Lexington has gone beyond the state of experiment.

Mr. LIEFF: And the cost per addict per year at River Side, I figure to be a little over six thousand dollars a year?

Dr. DAVIDSON: Yes.

Mr. LIEFF: Yes, is that what you make it?

Dr. DAVIDSON: Around six thousand dollars a year.

Mr. LIEFF: Thank you.

Senator HODGES: Doctor, may I ask a couple of questions? In the first place, are you giving your own views or the views of the Department of Health?

Dr. DAVIDSON: I'm giving my own views primarily, which have been obtained mainly from consultation with authorities elsewhere, but they also represent the Department of Mental Health Services' views.

Senator HODGES: One other thing I would like to ask, would you care to comment, or would you rather not, on the suggestion that dispensaries (we'll call them dispensaries) be established from which addicts could obtain drugs either free or at a very low cost. Have you any views on that subject?

Dr. DAVIDSON: I have my own views which are arrived at, after some deliberation. They are not arrived at, obviously, from a result of experience. My own views are that I would be definitely opposed to the establishment of clinics for the dispensing of free drugs to drug addicts. I cannot see that such a program would result in any definite improvement of the problem of drug addiction.

Senator McKEEN: Doctor, you said that in Lexington they have a cure there from ten to twenty per cent. What is the breakdown on that between the voluntary and the committal cases?

Dr. DAVIDSON: I'm sorry, I can't answer that. I don't recall, if I have heard, I don't recall the figures.

Senator LEGER: Doctor, would you know the amount of the younger group of people?

Dr. DAVIDSON: That again I am sorry I cannot answer.

Senator STAMBAUGH: Doctor, you mentioned that you considered that they should have absolute security. Now, you didn't mean food, clothing and shelter, entirely? You meant that they would be actually locked up, and—

Dr. DAVIDSON: They would be segregated.

Senator STAMBAUGH: —segregated and isolated?

Dr. DAVIDSON: Yes.

Senator HODGES: Another question I would like to ask, doctor. You were saying that the only addicts you have contacted were those who go into Esson-dale with psychosis.

Dr. DAVIDSON: Yes.

Senator HODGES: Are those psychoses aggravated by drug addiction, or have they had a psychosis before drug addiction?

Dr. DAVIDSON: They are usually inter-related with their drug addiction problem. One could fairly reasonably say that they were caused by the drug addiction although there are probably other factors responsible for the psychosis as well as their drug addiction.

Senator HODGES: Are you able to cure them of their drug addiction, in your institution?

Dr. DAVIDSON: We are only able to relieve them, to withdraw them. We have never had (in my time) sufficient to make a real study as to what happened after they left the hospital, whether they reverted or not.

Senator HOWDEN: Dr. Davidson, in the treatment of such addicts as you have had association with, have you ever considered the possibility of finding an antidote for drugs?

Dr. DAVIDSON: I haven't. At Lexington they have a very extensive Research Department and I have talked to the head of that Research Department and there have been very definite attempts to find some antidotes—

Senator HOWDEN: I think it is a possible way out.

Dr. DAVIDSON: Oh, yes. We can't foresee what might be found to counteract the effects of drugs.

The CHAIRMAN: Any other questions, honourable Senators? If not, we thank you most sincerely Dr. Davidson.

Magistrate Dohm will be our next witness honorable Senators.

Mr. DOHM: Mr. Chairman, honourable Madam Senator, honourable Senators, if I may be permitted to say for a moment, I would like to state that some people may not be of my opinion that this investigation is going to do some good. But I feel that you are focusing the attention of everybody in Canada on the seriousness and tragedy of anybody tampering with narcotics. Your coming out here I feel, Mr. Chairman, is a great service to the Canadian people. I think the Federal Government is to be congratulated on sending a high type of leading Statesmen to comprise this Committee to study this subject. I feel that even if you decide later on that the present addicts are incurable, you will be doing a terrific service to Canada by alerting everybody, especially the young people, as to the fact that no one can escape entirely if they tamper with narcotics.

Now, I have had considerable experience, I think, (not considerable as a Magistrate; I've only had one year's experience as a Magistrate, Mr. Chairman, and that year, with the exception of about the last month, I think I handled nearly all the narcotic cases in this area) as a lawyer I was in many narcotic cases, probably all of them in the last ten years. If I may be permitted, I would like to state that we are very proud of Warden Douglass. He came up here and gave his opinion. He is a very humble man, he did not tell you that he has been in that penitentiary for I don't know how many years—I think he's going on the outside in June—but he has worked his way right up to the top of being Warden and his opinion is really the result of possibly thirty or more years of seeing addicts in the penitentiary. I'm going to tell you later on that I agree with the opinions that he expressed, but I wanted to point that out to him. A lot of things have been credited to us here; we're supposed to have the highest divorce rate; the most addiction and the most juvenile delinquency, but I think we have the best run penitentiary in the Dominion of Canada and that is thanks to Warden Douglass.

Now, Mr. Chairman, may I have your permission to call two witnesses. We have heard a lot of discussion about addicts and how they get that way, and what happens to them, whether they can work or not, what amount of narcotics they use. Now, I have two witnesses here, but to put them up here in front of an august body like you people and expect them to talk right off would be difficult. I would like to have permission of calling them up here without naming their names. I will give the names to the Secretary, and ask them some questions so that they can talk more freely.

The CHAIRMAN: Agreeable?

Committee: Agreeable.

Senator TURGEON: Purely voluntary, are they?

Mr. DOHM: Yes, I will bring that out, Senator. Will you come forward, gentlemen?

Mr. DOHM: How old are you?

WITNESS: Twenty-seven.

Mr. DOHM: I might state, honourable Chairman, and Senators, that this gentleman did not expect to come up here today. When I contacted him I told him what you people were trying to do and unless you heard from their side of the picture that you might be handicapped and he agreed to come here.

The CHAIRMAN: He really came voluntarily?

Mr. DOHM: He came here voluntarily, not because I am a Magistrate or anything like that. I understand previously you were going to come up here but one of the papers published your picture without your consent and you didn't like that so you weren't going to come.

WITNESS: That is right.

Mr. DOHM: And you are here now and these people have come out from Ottawa here to learn first hand about this problem and you want to say something, don't you?

WITNESS: Yes.

Mr. DOHM: How old are you now?

WITNESS: Twenty-seven.

Mr. DOHM: And are you an addict?

WITNESS: Yes, I am.

Mr. DOHM: Now, I have told you, have I not, that there is no point in coming here unless you are willing to tell the truth, haven't I?

WITNESS: Yes.

Mr. DOHM: What amount of narcotics do you use now?

WITNESS: About five or six a day.

Mr. DOHM: Five or six capsules a day?

WITNESS: Capsules.

Mr. DOHM: And are you working?

WITNESS: No, not at the present.

Mr. DOHM: Now, I understand that you have served two terms of incarceration as the result of narcotics, is that correct?

WITNESS: Yes, that is right.

Mr. DOHM: And from one of those terms you were just let out recently?

WITNESS: Yes, about three and one-half months ago.

Mr. DOHM: And that was a three year sentence, wasn't it?

WITNESS: A three year sentence.

Mr. DOHM: And the term of imprisonment prior to that was how long?

WITNESS: Twenty-one months.

Mr. DOHM: And also for being in possession of narcotics?

WITNESS: Yes.

Mr. DOHM: Now, dealing with the last time when you got out of custody, were you in good health when you were released?

WITNESS: Yes.

Mr. DOHM: Warden Douglass mentioned that you get good food. You were in good health, were you?

WITNESS: I was in good health.

Mr. DOHM: And did you have an operation while you were in there?

WITNESS: Yes, I did.

Mr. DOHM: So that you were, as far as you were concerned, in good health?

WITNESS: Yes, I was.

Mr. DOHM: While you were in the penitentiary in custody, did you think about drugs?

WITNESS: I did.

Mr. DOHM: When or how often would you think about drugs?

WITNESS: Well, as long as my mind was occupied and that, during the day and that I wouldn't, but it always seemed to come up every day. It enters into your mind and you just can't seem to help it.

Mr. DOHM: Was that during the entire term of your imprisonment?

WITNESS: Yes.

Mr. DOHM: Now, when you got out, what happened?

WITNESS: Well, I was sincere in trying to keep away from it but from the Law's point of view and from being put in jail, well, it's unexplainable, there's just something you can't—in my own case—I just can't fight the urge, that's all.

Mr. DOHM: How much schooling did you have, by the way?

WITNESS: I went through grade nine.

Mr. DOHM: Was there some private schooling in there too?

WITNESS: Yes, sir, I had two years of private schooling.

Mr. DOHM: So you went back to drugs, didn't you?

WITNESS: Yes.

Mr. DOHM: And when you go back, do you go back in full force, or do you go back gradually.

WITNESS: No, I went back gradually.

Mr. DOHM: And, at any time, have you been able to carry on employment while you were also using drugs?

WITNESS: Yes, I have had a couple of jobs but I was never able to hold them just because I couldn't get enough money for narcotics.

Mr. DOHM: If you got the narcotics that you required, would you have been able to do the jobs that you had?

WITNESS: Oh, yes, quite well.

Mr. DOHM: Without mentioning any names of any businesses, would you give the honourable Senators what type of work you were doing?

WITNESS: In one place I was bookkeeping—junior bookkeeper—and another I was night manager of a cafe, a restaurant.

Mr. DOHM: Night manager?

WITNESS: Assistant manager.

Mr. DOHM: Bookkeeper and assistant manager of what?

WITNESS: Restaurant.

Mr. DOHM: Now, as far as doing your work is concerned, could you do your work while you were taking the drugs?

WITNESS: Oh, yes, very well.

Mr. DOHM: You said you couldn't keep the employment because you couldn't make enough money to buy the drugs that you required?

WITNESS: My salary wouldn't come anywhere near what my drug requirement was.

Mr. DOHM: Did you try cutting down on your drugs?

WITNESS: Yes, I did. I tried to get it down.

Mr. DOHM: What happened then?

WITNESS: Well, I just wasn't successful at it, that's all. I wanted the better things in life and I thought possibly I could keep working and buy a little at a time and take some to work with me without anybody knowing it. I would go to the restaurant and administer my drugs and—

Senator HOWDEN: Mr. Magistrate, I would like through you for you to ask the witness if he has at any time in the past several years been completely freed from the craving for drugs.

Mr. DOHM: Yes, that's a good question, Senator.

Did you hear that? The Senator wants you to answer truthfully if at any time during the past—

How many years, Senator?

Senator HOWDEN: Perhaps, five or six years, I don't know how long it is since he commenced.

WITNESS: Not since I had my first taste of drugs, my first introduction to drugs.

Senator HOWDEN: Since the beginning, you've always had the craving?

WITNESS: Yes, it's been—I don't know whether "sub-conscious" would be right or not—

Senator HOWDEN: I quite understand. I am a medical man and I can appreciate quite well your case.

Senator TURGEON: How long since the beginning?

Mr. DOHM: When did you first start using drugs? In 1944, how old were you? I know his record, Senators. How old were you then?

WITNESS: I've been using drugs about seven or eight years.

Senator McKEEN: I wonder if the witness could speak just a little louder please?

WITNESS: About seven or eight years, sir.

Senator HORNER: 1944?

WITNESS: No, it would be later than that when I started. About 1946 or '47.

Mr. DOHM: 1946. Do you get hungry for food?

WITNESS: Oh, yes.

Mr. DOHM: And if you have sufficient funds you buy food and eat, do you?

WITNESS: Yes.

Mr. DOHM: And if you don't have enough money to buy drugs and food what do you buy first?

WITNESS: I would have to buy the drugs first.

Senator HOWDEN: And as long as you're taking the drugs you feel pretty well?

WITNESS: Yes, sir, very well.

Mr. DOHM: A senator just suggested to me that I ask you what started you to use drugs?

WITNESS: In my case it was more out of curiosity at the time. I was serving a small jail sentence for a car theft. I was about fifteen or sixteen years old at the time—sixteen years old I think it was. I was in jail with other addicts and just through talking and meeting the people that's all. When I was incarcerated I met a number of them. They never told me anything about it exactly, but I was always curious. It was a mysterious thing and when I got out I—

Senator HOWDEN: Let me ask you this question. While you were receiving the drug you could work pretty respectably well?

WITNESS: Yes, sir.

Senator HOWDEN: So long as you had the drugs.

WITNESS: Yes, sir.

Senator HOWDEN: And without the drug you couldn't bear to work?

WITNESS: In my thoughts I could bear to work but I couldn't physically, sir.

Senator HOWDEN: That's what I mean. You couldn't physically.

WITNESS: No.

Mr. DOHM: On the market, you hear a lot of conversation and discussion from the Mounted Police about the narcotic market fluctuating like the Stock Exchange, but at the average price of narcotics, what would it cost you per day to keep yourself in narcotics so that you aren't sick?

WITNESS: Oh, an average of twenty-five to thirty dollars a day.

The CHAIRMAN: How long did it take you to reach the six—you said you were using six—how long did it take you from the time you started until you reached the six capsules per day?

WITNESS: Speaking for myself, sir, about three and one-half months.

The CHAIRMAN: That quick?

WITNESS: I wouldn't want to speak for everybody. I imagine everybody's system isn't exactly the same.

Mr. DOHM: That is a high amount, isn't it? Six?

WITNESS: Yes, I suppose it is.

Mr. DOHM: And you have used more per day?

WITNESS: Yes.

Mr. DOHM: What's the most you have used?

WITNESS: Well, I have gone as high as twenty-five.

Mr. DOHM: And that depends upon the amount of narcotic that is actually in the capsule that you get?

WITNESS: Yes, sir. There isn't really a great deal in each capsule when it comes to pure medical—

Dr. DOHM: The other substances sometimes are most of the capsule like sugar and milk and so on?

WITNESS: Yes.

Senator HOWDEN: Definitely, if you have a reasonable supply of the narcotics you can undertake fairly strenuous work?

WITNESS: Yes, sir.

Mr. DOHM: On both occasions—you're back in trouble now as a result, aren't you?

WITNESS: Yes, sir.

Mr. DOHM: You're not before me, incidentally.

WITNESS: No.

Mr. DOHM: Each time when you have been released and you come back out, gone back to the narcotic, have you been able to decide, well, I'm going to the narcotic or I'm going to stay away from it? Have you had that decision that you could make?

WITNESS: Well, I wanted to stay away from it because of what it represents—going to jail, and so on. But, as much as I try, I find it impossible.

Mr. DOHM: I wonder if you would tell the honourable Madam Senator, and the other Senators, about the time when you were—when some people were trying to rehabilitate you and you went down to the corner store—remember? To get a package of cigarettes?

WITNESS: That was the time when I had spent about two weeks in bed trying to cure myself. I was beginning to feel a little physically better so they asked me to go down to the store at the corner for them. I said I would and at the time I didn't have any thought of going near drugs. I was living in a suburban district quite a ways from where I would be able to contact any drugs. As I was going down towards the store, it's very un-explainable, I can't explain it, but I saw the streetcar coming down and I, it went through my mind that if I got on that streetcar I could obtain some drugs. The other side of my mind kept saying, "I don't want to", because I went there voluntarily. I wasn't forced to, I was on no charges whatsoever. My freedom wasn't endangered—well, it's always endangered when you're on drugs—but, what I mean is, I hadn't had any immediate warning. So, I kept on going to the store arguing back and forth in my mind and the first thing I know I was on the street car, that's all. Every stop on the way down town I kept saying I'd better get off here, but it was just more (my case) than I could control. And when I got the drugs again—

Mr. DOHM: Are you interested in having a family and leading a normal life?

WITNESS: Yes, very much.

Senator HODGES: Are you married?

WITNESS: No.

Mr. DOHM: Have you desires along those lines, that you would like to have a home and a steady job and so on?

WITNESS: Yes, I would. I'd like to have a steady job and a home and family and everything anybody else would like to have.

Mr. DOHM: I wonder if you would tell (senators, you've probably heard this before; I haven't been here before) but I wonder if you would tell the honourable senators about whether or not you're able to rest properly when you're an addict, or are you worried that you will be broken in upon and so on. What sort of a life does an addict lead?

WITNESS: Naturally, there is no rest for an addict; no peace of mind. I believe that's one of the reasons why his health might go. I know I'm probably a medical case outside of addiction, with nerves, but directly from addiction.

Senator HOWDEN: Haven't you got the horror that you may be deprived of the drug?

WITNESS: Yes, sir.

Mr. DOHM: He says too, Senator, that he's probably a nervous case because he's worried all the time.

Senator HOWDEN: That's what he's worried about. And worried about being detected.

Mr. DOHM: And worried about being detected.

WITNESS: Yes.

Senator HOWDEN: It all piles up to the same thing.

WITNESS: Yes, sir.

Mr. DOHM: Do you think that the average addict, without something to rebuild his will, without some belief, do you feel that he can cure himself?

WITNESS: I wouldn't want to talk for any other addicts, but for myself I would say that—I wouldn't want to say that we're incurable because I think

I could possibly be wrong because there are people who have cured themselves, but must have found something (I don't know what it is) to rebuild their will somehow, but as for myself in my condition, I know that I'm incurable, so far.

The CHAIRMAN: May I ask a question? You understand your fears and worries now, but my question is, when you are confined for an offence and your drugs were cut off, did you have the same worry then as to not being able to obtain drugs as you have now?

WITNESS: When I was in the penitentiary, you mean sir?

The CHAIRMAN: Yes. Did it worry you, the fact that after you came out you weren't going to get drugs?

WITNESS: No, because I was hoping that there was a chance that I would be able to stay away from it. I know drugs are out here for the wanting, but I was hoping all the time that I'd be able to keep away from it. But every day there did seem like there was something missing.

Senator TURGEON: Were you able to sleep properly when you were deprived of drugs?

WITNESS: Well, I slept fairly normally but as I say, it would enter my mind every night, sir. In the penitentiary that's the time—at night—when you're—I don't know, I always thought more myself. You know when you lay down to sleep, I guess everybody thinks then.

Senator TURGEON: But you would sleep after that?

WITNESS: Yes, but the craving would be there just a little. It's very hard to explain.

Senator HOWDEN: Were the drugs cut off in the penitentiary?

WITNESS: Yes, sir.

Mr. DOHM: Witness, the honourable Senator Hodges has this question. Was any attempt made by, say, the John Howard Society or any other organization, at your request or at their request, to rehabilitate you? Was there any treatment like that when you were released?

WITNESS: No, I never had any. I've been offered by the John Howard Society a couple of meal tickets—and the Salvation Army.

Mr. DOHM: They all do good work but that's what it consists of, doesn't it? It's in board and room?

WITNESS: Yes. I was offered by the John Howard Society—the Salvation Army on Robson Street I think it was, a place where I could sleep and get a couple of meal tickets, and I believe I was to report back there every day, until they found me a job but they said it was just about an impossibility because of my addiction background. With an addict background it is impossible to get work unless you happen to find the odd person who may be—I don't know whether it's sympathetic—or understanding, or something—who would take you with an addict background.

The CHAIRMAN: Would it be right to assume that requiring twenty-five or thirty dollars per day that it's impossible to carry on with drugs by working?

WITNESS: Yes, sir.

Mr. DOHM: I think that answers the question. You're not under oath and as I told you you won't get hurt by being here, but it seems pretty well accepted, and the records show that addicts are continually involved in not major crimes but petty crimes. You would agree with that, wouldn't you?

WITNESS: Yes, I would agree with that. I don't know of any major crimes. It seems to be the opinion that they pull all the heinous crimes but I've never heard of one. Of course, I haven't been around a great deal.

Mr. DOHM: Anybody going to rob a bank or commit a serious crime they wouldn't have anything to do with an addict, would they?

WITNESS: I don't think so. I would imagine—

Mr. DOHM: The addict might forget to keep the appointment?

The CHAIRMAN: Still the money is to be found, for the drugs.

Senator HODGES: That might come from petty crimes.

Mr. DOHM: It shows the type of activity that—

Senator McKEEN: I'd like to ask the question—how did he raise the twenty-five dollars a day?

Mr. DOHM: He just mentioned that.

Senator McKEEN: He said he couldn't work for it.

Mr. DOHM: The inference is there.

The CHAIRMAN: Magistrate Dohm, your witness has given us a lot of information.

Mr. DOHM: Apparently you gentlemen are in a hurry, but there's one question for the honourable Senators—

Mr. LIEFF: Oh, no, that is not what I said. I said there is somebody waiting here with a prepared brief and before we—

The CHAIRMAN: I think you have done very well.

Senator HODGES: I don't think it is fair to subject this man to any further inconvenience.

Mr. DOHM: There is one further question I think the Senator wanted to ask.

Witness, the honourable Senator on my left asks if you have ever tried to get away from Vancouver and this vicinity to get away from addiction and the people you know are addicted?

WITNESS: Well, every time I've been released from jail, it is financially impossible for me to leave right away and while you're under addiction in town here, naturally you can't leave or reduce yourself because there are only certain points in Canada where you can get drugs and to hit the road while you are addicted would be something I wouldn't want to tackle.

Mr. DOHM: Any other questions, gentlemen?

The CHAIRMAN: I think we have subjected him to a lot of questions and I think he has answered very well.

Senator BEAUBIEN: Very well.

Mr. DOHM: I have another gentleman here, I don't know if the honourable Senators wish to question him.

Senator STAMBAUGH: Is it along the same lines?

The CHAIRMAN: What is the wish of the Committee?

Senator HODGES: I think we should leave these men alone.

The CHAIRMAN: Is that the wish of the Committee?

Senator LEGER: Whatever he wishes himself.

Mr. LIEFF: Has he anything to add?

Mr. DOHM: No, it would be along the same line, but it is first hand.

Senator HOWDEN: You have the witnesses before us and if you want to put your man on the stand it's up to you.

Mr. DOHM: Thank you doctor. I'll forego that because it would be along the same lines as the previous witness, honourable Chairman. I asked this gentleman if he wanted to come here and he said he did and he's here. But it would be to the same effect that he has been able to work at times, providing he had the drugs and there is no need of taking up too much of your time.

Now, I understand that somebody is waiting here so I will be as quick as I can.

I am of the firm opinion that jailing is not the answer for this drug addiction.

Senator HOWDEN: Jailing and no treatment.

Mr. DOHM: I carry no brief for the drug traffickers. As a matter of record, I imposed the first ten year sentences on the drug traffickers that first came up under the Act as it now stands, and as you gentlemen enacted back in Ottawa. Those were ten year sentences which were upheld by the Court of Appeal of this Province and subsequently followed by other jurisdictions.

I would go along with Warden Douglass that, if clinics were established, I would go further and make the availability of drugs, which are practically of no value on the legitimate market, I would make them free, that is for the present addicts in any event. If that were done, I would go along with Warden Douglass in recommending that offence for trafficking narcotics should be a maximum of life imprisonment. There are different types of trafficking—the men that you hear about and that you very seldom see, the real traffickers—and nothing would be too good for them.

Senator HOWDEN: Where would you draw the line?

Mr. DOHM: For instance, there was a young fellow nineteen years of age who was charged with trafficking. I think Sergeant Price who is here knows about the case.

Senator HOWDEN: Was he an addict?

Mr. DOHM: Yes, he was an addict. He sold just two or three capsules a day in order to supply his own habit.

Senator HOWDEN: Now, it would be an unpardonable shame for that man to get life imprisonment.

Mr. DOHM: I gave him one year, but you see there are different types of trafficking, so that when I say life imprisonment maximum I'm dealing with men who are not addicts and—

Senator HODGES: Heads of the ring.

Mr. DOHM: Whose business it is to put up the drugs. Now those men, of course, the police will tell you, are never near the drugs. They have to get men who will take the risk of going near the drug and wrapping it up and preparing it, hiding it. They have to get men who will take that risk for money and also in order to get drugs to supply their own habits. They will take that risk. And those men that got the ten years sentences were actually "capping up" men. They were operating a capping up plant where the narcotic is mixed—

Senator HOWDEN: They were doing it on a big business basis.

Senator BEAUBIEN: Have you many of those men here?

Mr. DOHM: There are very few trafficking cases. The only way I think we can defeat the traffickers—and it's a very simple way I think—is to take the profit out of it. And the way to take the profit out of it and the way to take the profit out would be to give the drugs away to those who need it. There is tremendous profit in this business and it has been reiterated but I say it again at the risk of boring you, that the cost of supplying the 2000 or whatever addicts there might be would be negligible per day compared to paying \$4.89, or whatever a day it costs to keep them in free supply.

Senator HORNER: What about the danger of creating new addicts if that were possible?

Mr. DOHM: I don't agree with some statements that one addict will try to get another addict to be a user. Because one addict has enough trouble getting enough money to keep himself in drugs without getting his friends in that position, unless it happens to be a woman. If it's a woman then the man will try to get the woman to be an addict for other reasons. But ordinarily I don't think that one addict is interested in making an addict out of anybody else.

Senator STAMBAUGH: How do they become addicts if they don't contact another addict to begin with?

Mr. DOHM: Well, I think maybe it has been pointed out here, they have to be of certain temperament first of all before they will become addicts.

Senator STAMBAUGH: Don't they have to contact another addict practically every time?

Mr. DOHM: They know where the sources are available.

Senator STAMBAUGH: The addicts do.

Mr. DOHM: Yes, the word gets around. They congregate in special places.

Senator HORNER: Here's the difficulty as I see it. Here's a habit, at present it's very expensive. You make it entirely free. But then the unstable person thinking of acquiring a habit say, well, if I'm an addict I'll get doses free. There's the danger I think. No jail, no cost if I do.

Mr. DOHM: There won't be any perfect system ever evolved but you gentlemen, I notice, mention the Kentucky plan and other plans and you will no doubt study what has been done in other countries. Nothing will be perfect and probably somebody, I'm not minimizing the tragedy of anybody getting hurt that way, but I think in justice to the addicts who are addicted, if we can't do anything it isn't humane to continually slap them in jail for what they are doing.

Senator STAMBAUGH: Are you quite sure that your system of free drugs will not create more addicts than the present system?

Mr. DOHM: It wasn't my system although I was on the Committee of the Community Chest and I voted in favor of it. But I don't think anybody—and that's why I say you gentlemen are doing a good work, because you will alert the people to the dangers of narcotics—and I don't think anybody without some weakness—

Senator HOWDEN: You are a justice of the peace—

Mr. DOHM: I am a Magistrate, yes.

Senator HOWDEN: Yes, you're a Magistrate then. And you're giving us, to the best of your ability, your advice with regard to this matter.

Mr. DOHM: Just my idea.

Senator HOWDEN: Certainly, we have every reason to respect the testimony and I think we can take it at that and leave it go.

Mr. DOHM: I would like to point out in fairness to British Columbia that, according to the press in any event, Dr. Stevenson said that British Columbia leads throughout Canada in juvenile delinquency. I don't know where that fits into the picture here as far as narcotics are concerned, but since we are getting the publicity on it, I would like to point out that in Ontario, Alberta, Saskatchewan—I don't know about Quebec—that the juvenile age limit is sixteen whereas ours is eighteen. So, if you take away all the delinquencies out here at sixteen years or seventeen years, I don't know exactly what the figure would be but I am sure, in my opinion, that the delinquency rate here would compare favourably with any other province in Canada.

The CHAIRMAN: That would make some difference, Magistrate.

Mr. DOHM: Our figures show that many of the delinquencies occur in those ages. Now, I have obtained, if it is of interest to you, and I am sure it is, some figures from Mr. Harry Robson, who should receive the credit for doing this work. He is the Deputy Chief Probation Officer for Vancouver, and he has prepared for me some figures covering the years 1952, 1953 and 1954,—three years. I know how much you are concerned about how many, if any, children or juveniles are in this unfortunate position. I'm not minimizing those who are, but of 2,349 cases dealt with by the Vancouver Juvenile Court in those years—

Senator HODGES: Excuse me, that is cases of all kinds?

Mr. DOHM: That is right, yes Madam Senator. The known confirmed drug addicts total sixteen. As I say, it's unfortunate for those but I wanted to show you that the figures by far are—

Senator McKEEN: What ages are those? Under eighteen?

Mr. DOHM: They're all under eighteen to be in our Courts. Thirteen of those sixteen were females and they are quite positive in Juvenile Court that no children who were attending school at the time they committed delinquencies were taking drugs. An additional four delinquents later became confirmed addicts and it is very certain that they graduated into the ranks of users after they became eighteen but we have no figures in this regard. Of the known addicts, sixteen in number, only four were charged with possession of drugs; three being transferred to the Magistrate's Court for trial; one sent to Hollywood Sanatorium for treatment with no success and subsequently committed to the Girl's Industrial School. This group of four consisted of three girls and one boy. The evidence that the twelve are confirmed addicts came from their own statements, physical proof shown by punctures in their veins, withdrawal pain and confirmation by police evidence.

There is a chart here which I will file, possibly, I don't know if you want a copy of it, but it breaks down the years separately, the number of boys, number of girls and it's under different headings, but if you add the totals up you'll see that the figures I gave are correct.

You have a lot of matters to cover. I received a nineteen page letter from an addict whom I've known for many years. He is presently in the Tranquille Sanatorium near Kamloops.

Senator HODGES: That is TB?

Mr. DOHM: Yes. And quite likely there is quite a bit of humour in it too. You won't hear much humour in this business but he tells the same story. I wired him and asked if I could have his permission to read the letter and he wired back that I have his absolute permission. But I won't take the time to read it—

The CHAIRMAN: We'll put it in as part of the record.

Senator HORNER: What age is he now?

Mr. DOHM: He's about thirty-five or thirty-seven.

The CHAIRMAN: We'll make it part of the record.

Mr. DOHM: He is a barber by trade and he tells about trying to carry on his barbering, which he could do when he got the narcotics and so on.

Senator TURGEON: How long has he been a narcotic?

Mr. DOHM: Oh, for many years, sir. He mentions one offence that I know about. About five or six years ago and he was an addict before that. He has presently, due to worry and so on, contacted TB, and he is up there. So, if I may, with the understanding that his name will not be divulged, and the places and his parents whom he mentions, may I file that?

The CHAIRMAN: Yes, thank you. Before you go, I have just one question that has rather puzzled me. If you can't answer, of course, don't, but the statement has been made when speaking about the great number of addicts in

Vancouver, and the crime, that perhaps the sentences given here are not comparable with the same crimes committed, say, in the City of Toronto or Montreal. Would you care to say something about that matter? Because it has been stated to us that that might be one of the reasons for—

Mr. DOHM: One reason the addicts congregate here is because of our good climate. That's something B.C. has that they haven't got back East.

Senator HORNER: I thought maybe the climate made them addicts.

Mr. DOHM: No, they're able to withstand the weather here better than they could back there for one thing, but I think our sentences, if anything, are more harsh than they are back East.

Senator McKEEN: I don't know whether you know the answer to this, but is the price in Vancouver higher or lower than it is in Montreal, Toronto or other cities?

Mr. DOHM: It depends upon what sort of cases are before the Courts—

Senator McKEEN: I mean the price of drugs.

Mr. DOHM: That's what I'm speaking of. If somebody has just received a ten year sentence, the price goes up like the oil market, and if things are going along fine, nobody is in trouble, the prices are cheaper.

Senator McKEEN: Or every time the R.C.M.P. seizes a shipment, the prices go up to make up for it, is that it?

The CHAIRMAN: I appreciate your answers, Magistrate.

Mr. DOHM: I would like to say with respect to Chief Constable Mulligan too, that I do not agree with him about the majority of crime being traced to the addicts. I have more figures on that but I can't take up all the time, but I would say only about 7 per cent, just basing it in, say, the last six court cases that Magistrate Scott and myself had. I would say only about 7 per cent of the crime had anything to do about addiction or drugs. That is only petty crime. None of them are ever involved in serious crime.

Senator HODGES: Not involved in more violent crimes?

Mr. DOHM: Only the traffickers. The addicts like you saw today are not involved in serious crime. Nobody will have anything to do with them when making any plans, they aren't reliable enough. They don't have any pre-meditated crime. They might commit a breaking and entering, but they won't look the place over beforehand. They'll be walking along—

Senator HODGES: They don't plan bank robberies or—?

Mr. DOHM: No, nothing like that. Just petty thefts.

Senator STAMBAUGH: Do you consider that their evidence is reliable?

Mr. DOHM: Well, I can't see why not when they come here. You'll no doubt hear others too, but I personally feel that it is reliable.

Senator STAMBAUGH: Do you consider that their evidence is reliable?

Senator HOWDEN: That man that you brought here today was a straight talker.

Mr. DOHM: I personally feel that the man you heard here today was telling the truth.

Senator STAMBAUGH: Oh, yes.

Mr. DOHM: Thank you very much.

The CHAIRMAN: Sergeant Price, would you please come forward?

Mr. LIEFF: You are Sergeant Harold F. Price in charge of the local narcotic squad of the R.C.M.P.?

Mr. PRICE: I am, yes.

Mr. LIEFF: And you have been in charge of that squad and doing this kind of work for about seventeen years?

Mr. PRICE: I have twenty years service in the force, of which seventeen years have been employed on narcotic enforcement work in this City.

Mr. LIEFF: Thank you.

The CHAIRMAN: Do you have a paper?

Mr. PRICE: Yes.

The CHAIRMAN: Will you proceed, please.

Mr. PRICE: Mr. Chairman, honourable members, this statement, representing the local R.C.M.P. viewpoint of the illicit narcotic trade in the metropolitan Vancouver area, has been prepared by drawing upon the experience of the N.C.O.'s and field men of the R.C.M.P. Vancouver Narcotic Branch. It has been compiled from local statistics and reflects the facts and practices that exist here. Commissioner Nicholson has described the national problem, and he has defined this Force's policies governing the enforcement of the Opium and Narcotic Drug Act. It is an accepted fact that this city has the greatest concentration of narcotic infection in Canada. Although there are addicts living in Victoria, Prince George, New Westminster and Prince Rupert, nevertheless Vancouver attracts the addicts in every way. Vancouver is their home. Monotonously, it has been the case that, as a result of their criminal associations in Vancouver, they progressed into addiction, and, having progressed into this class of criminality, the addict considers Vancouver as being synonymous with a concentration of addicts, and, following the laws of supply and demand, this City is further considered as a possible source of supply on the street level.

The policy of the R.C.M.P. is to pursue the trafficker rather than the addict. When an investigation is instituted by another police force the facilities of the R.C.M.P. in the way of handling exhibits, analysis and supplying counsel, or any other assistance required, are available for the prosecution of the case.

In the earlier history of the enforcement of the Opium and Narcotic Drug Act, opium was the chief drug of addiction, and the addict, generally, was an Oriental residing anywhere within the lower Mainland, Vancouver Island, or on the main line of the railroads. Since World War II, however, the addict has been found mostly in the metropolitan area. Even though an addict will occasionally live or work sporadically in other parts of the Province, invariably he returns to Vancouver to his old associates. Today, the incidence of narcotic possession cases outside this metropolitan area is infrequent, occurring probably between 1 and 5 per 100 cases. This Force's Drug Squad in Vancouver has grown on a comparative basis with the growth of the problem.

Greater Vancouver's 242 square miles contain approximately a half million persons, and it includes the municipalities and cities of West Vancouver, North Vancouver, Vancouver, Burnaby, New Westminster and Richmond; it is protected by the West Vancouver Municipal Police, the New Westminster City Police, the R.C.M.P. and the Vancouver City Police. The resources of this Drug Squad are at the disposal of all of these police forces. The Vancouver City Police maintains its own Drug Squad, which works in close harmony with this Force's Drug Squad. Techniques and equipment, as well as narcotic intelligence, are freely exchanged, and many of the prosecutions are as a result of joint investigation. Where a municipal police force or one of our own uniformed detachments has had little experience in narcotic matters, our Drug Squad will attend and assist in the furtherance of the investigation and the prosecution.

The R.C.M.P. Drug Squad undertook the census of local addicts, and, since that time, addicts' names have been added from time to time as they come to this Squad's attention. By actual count, the addicts in this area are as follows as of March 31, 1955:

553 persons free in Vancouver—consisting of addicts, peddlers and connections.

266 persons associated with the narcotic traffic presently in the British Columbia Penitentiary.

172 persons associated with the narcotic traffic in Oakalla Prison Farm.

Since the census was completed in 1947 a total of 357 new addicts have come to our attention. Of these, 83 new addicts were added in 1949, 105 in 1950, 72 in 1951, 26 in 1952, 19 in 1953, 45 in 1954, and so far this year 7 new addicts have come to our attention.

I would refer you briefly to Commissioner Nicholson's statement to you on March 22nd, at page 11, with particular reference to that portion relating to juvenile addiction. You will recall he told you that across Canada, in a study of 2,000 addicts, only 25 men and 29 women were less than 20 years of age when first convicted under the Opium and Narcotic Drug Act.

The possibility of juvenile addiction is a factor to which this Force pays very close attention, and every allegation or piece of information concerning this possibility is carefully and thoroughly investigated; to date, there has been no discovery of addiction on the part of students within the schools of this area. Whilst there are a few instances of juveniles of school age becoming addicted, these juveniles were by no means school children, but were graduates of juvenile detention homes and corrective institutions. In each of these cases, there has been a history of delinquency prior to addiction. In this regard, the Vancouver City Police maintain a Youth Guidance Detail, to whom all complaints and instances of juvenile delinquency are referred for investigation and who, therefore, have an excellent knowledge of the juvenile situation in this city. Our Force has maintained close liaison with the Youth Guidance Detail with respect to the possibility of juvenile addiction. During the so-called "juvenile trials", which occurred in this city during 1952, there were 8 juveniles involved, and the critical age in each was 17 years. All 8 had a history of some form of juvenile delinquency, and each was introduced to addiction by one of the same group.

The introduction of narcotics to Canadian addicts does not follow the pattern prevalent in the United States. In that country, published reports indicate marijuana plays a major role in the recruitment of addicts, many of whom are juveniles. Here on the West Coast, and in other parts of Canada, this has never been the case. As the Commissioner of this Force has stated, there is no marijuana problem in Canada.

Today's new addict in Vancouver first experienced narcotics in the form of heroin. Whilst opium and cocaine were pre-war problems, heroin is a post-war development, locally. Prior to 1939, the drug of addiction in this area was opium. Later, with the curtailment of shipping, due to the war in the Pacific, the opium stocks were depleted, and we then experienced a rash of drug store breakings and enterings, hold-ups, and safe-breakings, with the resultant diversion of legitimate drugs into the illegitimate market. Later, in the 1944 and 1945 period, a form of heroin made its appearance and within a year very little else but heroin was used locally. One factor in this would be that heroin is reported to be three times as strong as morphine; thus, a person addicted to heroin will not obtain full satisfaction from the weaker drug, morphine.

In most cases, British Columbia's source of narcotics in Eastern Canada, which in turn gets it from the Eastern United States. Contrary to what might be expected, there is relatively no flow of narcotic traffic either way between British Columbia and the Western United States. The fact that Vancouver is a seaport has no bearing on its source of narcotics at the present time.

Since 1949 this Branch has undertaken twelve major undercover operations in this area, aimed at top trafficking organizations. This is one of the most risky forms of enforcement as considerable danger can be experienced by the member of the Force working undercover. Whilst this is one of the most efficient methods of narcotic enforcement, it is also one of the most difficult to conduct. Since 1949, 89 prosecutions have resulted from a series of such undercover investigations, with all of the prosecutions being for sale of a narcotic. It must be pointed out that during the course of such an investigation the undercover man is usually living in the role of an addict criminal and associating entirely with the criminal element. Aside from the physical danger to be expected in such a role, more likely and more real is the danger of exposure, which can ruin months, and even years, of careful preparation and work on the part of many to place the one man in a position where he has gained the confidence of traffickers. It is a popular misconception that drug peddlers seek out and attempt to interest persons in the use of drugs. This is definitely not the case. Undoubtedly the drug trafficker—I am speaking of the trafficker, not the addict, would like to increase his profits by increasing his customers and there is no question of scruples or morals involved in his lack of effort in that direction. But the drug peddler is a shrewd, amoral criminal who, as they say, "plays all the angles". They know that the police are constantly attempting to penetrate their organization; dealing with newcomers is risky and would lead to rapid arrest. Therefore, they attempt to sell only to addicts who can be vouched for. That is one of the facts that makes enforcement work difficult.

Nothing has more sharply pointed up the West Coast narcotic traffic than recent acts of violence, but then the narcotic trade always did indulge in violence. With respect to this violence, it must emphatically be stated that it is not occurring on the level of criminal addicts but rather on the level of the non-addict criminal distributors, and it represents a see-saw battle of individuals or groups attempting to seize control of the narcotic traffic in this city, in just the same way as they might attempt to take over organized vice such as gambling or prostitution. As far back as 1936, elaborate precautions were necessary to safeguard the witnesses in an important conspiracy. In 1949, there were two separate incidents of violent assault attributed to narcotic traffickers. In 1950, an important trafficker was shot and wounded by another trafficker. In 1951, there were further assaults and a disappearance. In 1953, there were two shootings and several violent assaults. In 1954, there were further assaults and one murder. All of this refers to the difference occurring between narcotic traffickers. Regarding serious crime, may I point out that apart from the fact that he is usually a docile, submissive sort of a person, there is another reason why the addict does not become involve in major crime. Such crimes are organized and all criminals are aware that an addict is unreliable and if denied drugs for only a few hours will tell everything he knows.

Probably the question most unsatisfactorily answered, in the minds of enforcement officers at least, is what there is in the make-up of an addict that sets him apart from others. One would expect his addiction to manifest itself in his physical appearance. Several years ago, as an aid to training new members of this Drug Squad, we concealed a motion picture camera at a certain busy intersection in downtown Vancouver, focussed on an establishment frequented at that time by criminal addicts, and, in the period of about a week, something like 90 addicts were photographed. As a matter of interest, there

is nothing in their appearance to distinguish these addicts from the other passers-by. Under reasonable circumstances, the addict goes undetected in any crowd, and he is by no means the hollow-eyed, wild, hopped-up dope fiend the public is led to believe. Within the past few days further motion pictures have been taken of addicts in the same locale. These films are available to the Committee if the Honourable Members would care to see them.

The addicts encountered by the police are simply criminals who have progressed to taking drugs. Just as surely as some people will never resort to crime, certain criminals will never resort to narcotics, but the vast majority of the addicts on the streets of Vancouver today are criminals. It is fallacy that drugs lead to crime; the reverse is true.

Addicts very often speak of a desire for a cure, and it is almost impossible to find one who has not been, allegedly, cured of addiction, usually by means of enforced abstinence as a result of incarceration. I cannot speak as a medical man and I cannot say if a cure has been or will be found. I can, however, speak as a policeman with seventeen years experience in this field, and I think as one who has shared with most other policemen a deep sympathy for addicts and a desire to see a practical plan developed which will give them the best break they can get out of life. Speaking from that experience and from that compassion I can only say that I have never known an addict to be permanently cured.

It must be appreciated that these criminals became addicts because of their own wilfulness and that they were not seduced into addiction. This subsequent addiction is merely another step in a life of progressive criminality. Should the addiction factor be removed, then we are still faced with the original problem—that of a criminal.

Essentially, it would appear that too much emphasis is placed on the addiction factor, with insufficient reference to the primary factor of criminality. In essence, a criminal addict is as the adjective implies—a criminal first and an addict second. The problem of criminal addiction cannot be adequately approached and probably can never be resolved with emphasis on the addiction factor only and not on the primary factors, which are those of delinquency in the juvenile and of criminality in the adult.

Enforcement of the Opium and Narcotic Drug Act, alone, has not curbed the problem of addiction and the subsequent trafficking in drugs. In this connection, every modern enforcement technique is utilized in the unending war on distributors. No gang of narcotic traffickers operating in this area has gone unscathed. The records of the British Columbia Penitentiary contain the names of these would-be kingpins. Some of these racketeers have lasted only months while others have lasted several years; however, in the end each of these groups has been broken up. Despite these involved investigations and convictions there is no respite in the traffic, because it is too lucrative a field for criminals to vacate, and when one trafficker is removed, his place is taken by another. With the profit involved, the risks are overshadowed in the criminal mind.

The problem seems to be akin to the law of supply and demand, and to date enforcement emphasis has been on the source of supply and distribution; this not a full answer, as illustrated by the current situation. The supply continues, despite the best efforts of enforcement officers throughout the world. It would appear that attack must be made on both these factors, not only the supply but also the demand. As long as the addict exists, racketeers will supply his demand in the same fashion that any other criminal demand such as prostitution, gambling or bootlegging is supplied. The demand can only be removed by the removal of the addict. The removal of a few addicts or the voluntary treatment of a few addicts would provide an interesting experiment and might add considerably to medical knowledge of the motivation of addicts.

Such an experiment might in time even provide an answer, but at this moment I am afraid that such an answer is just a strong hope in the mind of everyone aware of this problem. That hope for the future should not be lost sight of but may I respectfully suggest, Sir, that apart from the hopes for the future, we need a practical answer today.

Senator HOWDEN: Hear, hear.

Mr. PRICE: A number of witnesses—and particularly those with years of experience with this problem—have suggested some form of isolation for all addicts and I would like to go on record as favouring that plan. And might I repeat, Sir, that I have the greatest sympathy for the addict. Certainly I think as a policeman, but as a policeman I know that the addict's lot today is hopeless. I know that 40 per cent of the addicts are in jail and the remainder living in poverty, filth and degradation all the time. I can't help wondering why the opponents of this suggestion seem to consider that isolation—meaning decent living conditions—a ray of real hope—would be a hardship. Nor can I help wondering why persons who favour isolation for other contagious or communicable diseases, while regarding addicts as medical cases, object to their isolation.

In conclusion, Sir, and without wishing to enter into a controversy, may I clarify one point that has been mentioned to this Committee regarding my Force, and a point to which considerable attention has been given by the Press. It has been stated that a former drug addict, while attempting to rehabilitate himself, lost his position through the intervention of this Force, and, therefore, returned to addiction. Leaving out only the names of the addict and the doctor, I would like to read into the record the instructions sent to the detachment concerned and the subsequent report from the detachment:

The subject, (Dr.), has for the past some time been experimenting with various addicts in an effort to devise a cure for drug addiction.

He has had as his patients several well-known drug addicts, one of them, (addict), whom he considers to be cured of addiction. (addict) has been given employment in the Western Uranium Mines Ltd., at Skeena Crossing, B.C. The doctor has instructed him to introduce himself to the members of our Detachment in that area and to explain the treatment that he has undergone.

Please have enquiries made without incurring any embarrassment to (addict), and ascertain whether or not he is refraining from the use of narcotics. This should be done without arousing any suspicion of his fellow-workers or management, in order to give him a complete chance of rehabilitating himself.

Please report this matter under the above heading.

And the reply:

Reference the above and further to memorandum of the 4th instant in the above connection of the Officer i/c., C.I.B., Victoria, B.C., I beg to report as follows:

Enquiries conducted at this point reveal (addict) since employment with the Western Uranium Mines Ltd., at Skeena Crossing has been a good worker and of good character, appears to have refrained from the use of narcotics.

It is understood this subject stays most of the time at the mine which is situated about 30 miles West and South of Hazelton, B.C., and as yet has not contacted either Const. or myself as mentioned in the above noted memorandum.

With reference to that particular case, that addict in question, at that time, it was in 1951, had a criminal record which included convictions for retaining, perjury, possession of house-breaking instruments by night, possession of explosives, breaking and entering and theft, unlawfully obtained lodging, possession of opium, stealing and vagrancy.

That is the end of my prepared submission, Mr. Chairman.

The CHAIRMAN: Any questions to Sergeant Price?

Mr. LIEFF: Just a question or two with respect to the liaison cooperation between your force and the municipal force. It has been said by members of that force that there is complete cooperation, exchange of information and that sort of thing. I consider it excellent that you lend each other men.

Mr. PRICE: As a matter of fact, at this precise moment there are six members of the City police working out of my office and, by the same token, there will be some of my men working out of the City Police Detective office—really inter-changeable.

Mr. LIEFF: You give each other desk space and that sort of thing.

Mr. PRICE: That is correct.

Senator LEGER: How many men do you have in your Force?

Mr. PRICE: I have twenty-one men in my squad, sir.

Senator LEGER: On narcotics?

Mr. PRICE: Working on narcotics only to the exclusion of all other duties.

Senator TURGEON: Those are twenty-one of your own regulars, is it?

Mr. PRICE: Twenty-one Mounted Policemen in our Drug Squad.

Senator HOWDEN: I gather from your submission, Sergeant Price, that you are not opposed to isolation?

Mr. PRICE: No, I am not, sir.

Senator HOWDEN: And with regard to free clinics?

Mr. PRICE: Well, may I answer that in this way, senator. As far as isolation is concerned, I consider that every addict is a source of infection to all his associates. Not necessarily wilfully, but by his very example. It's comparable to having a rotten apple in a barrel. If you leave that apple in you have a whole barrel full rotted.

Senator HOWDEN: Quite so. Now then, about the clinics.

Mr. PRICE: As I stated in my submission, I consider these people victims of their own wilfulness. I think our efforts would be better devoted to restricting addiction rather than spreading it, and I consider that clinics would spread it.

Senator HOWDEN: That is so. Then, you are not in favour of clinics but you are in favour of isolation.

Mr. PRICE: Definitely.

Senator HOWDEN: That's what I want.

Mr. LIEFF: There was a proposal made yesterday by a witness that an opportunity be given to addicts to undergo treatment. That is, to undergo withdrawal and then to be followed by treatment. But that if they didn't care for that, didn't want that or accept that, that we supply them with drugs. Now, in the light of your seventeen years of experience, witness; of the addicts that you know, what proportion of them would accept treatment rather than the chance of getting free drugs.

Mr. PRICE: Well, there is no alternative in their minds. It would be free drugs.

Senator HODGES: May I ask Sergeant Price, I notice in your report, about a census you took in 1947.

Mr. PRICE: Yes?

Senator HODGES: 83 new addicts 1949, 105 in 1950, 72 in 1951, 26 in 1952, 19 in 1953—45. Can you give any reason why there should be that decline?

Mr. PRICE: No, I can't offer you any reason, Madam Senator. It's just that is the total number of people that have come to our attention in those years.

Senator HODGES: But there is a marked decline from 105 to 19 in 1953, for instance, and I wondered if there were any reasons that you could give for it.

Mr. PRICE: No, I can't. You will notice that the figures fluctuate.

Senator HODGES: Oh, I notice that.

Mr. PRICE: I can't see any pattern established at all.

Senator HORNER: Sergeant Price, those additions during those various years, would you say that they were entirely local, Provincial additions, or does that include people coming in.

Mr. PRICE: That includes persons from other Provinces coming into Vancouver, but becoming addicted here.

Senator BEAUBIEN: Mr. Chairman, I think we had a witness that advocated very drastic amendments to the Narcotic and Drugs Act, in order to make it easier to enforce, do you remember that?

Mr. PRICE: I didn't hear that witness, sir.

Senator HORNER: That was to the effect that they be allowed to arrest a man if they were suspicious or thought he swallowed something, and take and hold him for twenty-four hours.

Senator TURGEON: Forceful accommodation, that's what you mean, for supposed suspects.

Senator BEAUBIEN: Very severe amendments to the Act.

Mr. PRICE: That's rather hard to answer, sir. I would point out that under circumstances such as that, the answer could be to lay a charge and thus he would be committed to the Provincial jail at Oakalla which does have that power to forcefully extract the stomach contents which would be an answer to that.

Senator HODGES: But you wouldn't be willing to give it into the hands of the local police?

Mr. PRICE: Oh, I wouldn't say that. As a matter of fact, I haven't considered that, Madam.

Senator McKEEN: I wonder if that statement is correct. I was speaking to a man today (a lawyer) who had prosecuted in these cases and that had been done. And they said they were going to take action but they never did take action. The action was supported by the court and he said there's nothing in the Criminal Code that precludes them from doing that. Now, I don't know, that man would be prepared—he's one of the outstanding attorneys here—and he has prosecuted under the Opium Act for many years—

Senator TURGEON: Is this done by the jail authorities or by the—

Senator McKEEN: Done right by the City police in Vancouver at the time, and he said there was nothing there that would stop it and he's prepared to give evidence in that regard. He's a man of high standing in the profession.

Mr. PRICE: I can point out one example, sir, of a rather important personage in the narcotic traffic, a non-addict, who, because he thought our men were right behind him, he forced a bundle of heroin in a rubber sheet, containing forty capsules, down his throat—literally pushed it down his throat. The bundle was about that long and a diameter of that, and in fear of apprehension he forced that down his throat. He later attempted to remove it by normal means and failed—he took a number of laxatives and it still failed—and three

days later on a Sunday evening, he broke out into a sweat, with heart palpitations and he feared that the container had burst in his stomach. Forty grains would be twenty times a lethal dose for a non-addict, and he went screaming down the hallway of his apartment house and asked for an ambulance which took him to the Vancouver General Hospital emergency. All emergency calls are answered by Vancouver City Police so consequently the man answering the call recognized this "friend" of mine, shall we say. We were notified and in the interval he had been examined by the interne and told him what was wrong—that he had this container in his stomach and the dosage he had—and once it was explained to the interne that the ends were knotted and there was double thickness—he told him he was in no danger of his life, that the rubber would remain inact indefinitely, almost impervious to the stomach acids. Then he started thinking it was a little odd, heroin in that form and in that quantity and in that form of container, so he suggested that he take steps to remove it, but the patient, once he was assured there was no danger, refused treatment. It was at that point we arrived. So, we gambled and laid a charge of possession against him because he admitted that he had swallowed forty grains. Mind you, we had no evidence. He refused to accept medical treatment for a period of seven days and during that period he was remanded by the Magistrate, without bail, and he was under our guard in the General Hospital with two of our men twenty-four hours a day. He was most suspicious that we would attempt to introduce a laxative to him and for breakfast all he would have was a boiled egg in the shell and he would examine the shell very carefully to see that it was not cracked or needle marks in it, and he would only drink clear tea, no flavouring in it (no sugar) and this went on night and day for eight days. On the eighth day he was reproduced in Court, the day of the adjournment, and he thought he could probably get bail. Once he got bail we had no case. When he came up the Magistrate asked if the evidence had been secured and we reported no, so the Magistrate remanded him a further week. The peddler then gave up, he realized it was futile to hold out any longer. He signed a waiver accepting medical treatment. The treatment was begun at 1.00 p.m. and the Crown did not obtain its evidence until about 12.30 that night and with a lot of medical care it was finally recovered. He stayed in hospital over night of course.

Senator HOWDEN: By incision or by—?

Mr. PRICE: No, through passage in the normal fashion.

Senator STAMBAUGH: Intact?

Mr. PRICE: Yes, the capsules were compressed by the muscular contraction of the bowels but the drug and rubber container were intact. So, in some instances there are various devices to combat that.

Senator McKEEN: Well, in this case he said there was no permission of the trafficker to do this, it was done by force.

Senator HORNER: You got your conviction?

Mr. PRICE: He pleaded guilty.

Senator HORNER: Yes.

Senator McKEEN: He claimed that under the criminal code it couldn't be done. I don't know, I'm not a lawyer.

Senator BEAUBIEN: He was a trafficker?

Senator McKEEN: Yes.

Mr. PRICE: Actually, it occurred about 4.00 a.m. when he was on his nocturnal rounds making "plants"—he went to the well once too often.

The CHAIRMAN: We appreciate your attendance, Sergeant Price, and thank you very much indeed.

The Committee adjourned until Thursday, April 21, 1955, at 10.00 a.m.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

VANCOUVER, B.C., Thursday, April 21, 1955.

EVIDENCE

The Special Committee on the Narcotic Drug Traffic met this day at 10.00 a.m.

Senator Thomas Reid in the Chair.

The CHAIRMAN: We will now hear from the Reverend Blackburne.

Mr. BLACKBURNE: I don't pretend to present anything new to you, but there are one or two considerations I want to bring before you as a Committee and to submit them specifically for your consideration.

There is a question which, to my mind, has not yet either been asked or answered in the various submissions that have been made to you, yet it will prove basic to your whole consideration of the problem of narcotic addiction. Very simply, it is this, whether it is right or wrong to use habit forming drugs. On the basis of your answer to this question will be built any solution which may be proposed as an answer to the problem. I refer only to the habit of using drugs, as contrasted with the other related problems. It may be expedient to prevent addiction in individuals and in the community from many standpoints. Addiction may be regrettable from the psychiatric view, from the social side of the question, from the point of view of the individual's life, etc., but in itself, should addiction be classified as wrong? Or to put it another way, have I the right to say that another should not use habit forming drugs, in so far as they affect the individual and him alone?

Should the addict be considered as essentially bad, or as a person who is basically ill—in any sense of the word; physically, mentally, morally, spiritually or socially—to put it in these logical terms—is he sinful, or is he sick? Upon this basic question will rest the decision as to whether he should be punished or treated.

Then again, in relation to that general question, can any effective solution be found which depends for its effectiveness and permanence upon any kind of compulsion? A parallel may perhaps be drawn between addiction and certain contagious diseases, such as tuberculosis. But surely a patient who is compulsorily isolated, for the treatment and cure of tuberculosis accepts such treatment of his own will. He accepts the regulations concerning the treatment and prevention of tuberculosis because he himself wishes to be cured. He goes, recognizing his own sickness, and desiring health. Perhaps a better illustration may be drawn in the instance of social disease, for there is there a similarity with addiction in that the individual wilfully entered upon a course of action where the possibility of disease was prevalent. But even here, treatment for such disease is sought, or submitted to voluntarily. The question of compulsion, therefore, regardless of an opinion concerning it, just the simple question of compulsion, must be basic to your considerations. Some element of compulsion may, of expedience or necessity, enter into any solution that you may devise to the problem of narcotic addiction, but the ultimate effectiveness of any form of treatment which includes the element of compulsion must be evaluated and anticipated, in so far as it is possible to do so.

My second point then, if I may, I wish to refer briefly to the subject of legalization. Those who oppose it often refer to experiments in various places which have been classified as legalization, which experiments have failed. And I ask you humbly to investigate this claim closely, to be very sure that what has been referred to as legalization has, in fact, been that, or whether it has in reality been an attempt to retain addicts on a minimum dosage, or an attempted cure through a reduction or substitution. And, to assist you in your deliberations, I would offer the following as a true definition of legalization. The sale, at cost, to addicts of the drug they prefer, when they want it, in the quantity they desire. Legalization, as I have defined, may or may not be part of the answer to addiction; but it is essential that it be clearly defined whenever it is considered in relation to the whole problem.

I have two more points, the third one is this. I am deeply concerned that the present system, its results and all its associated evils, will weigh not too heavily as a factor influencing your approach to this problem. It is important to recognize the extent to which our present attitudes (I'm speaking of "our" in the sense of society) and our system of dealing with the problem have aggravated the situation. And any approach toward a solution cannot be based on the results of a system which has proven itself to be a failure. Put very simply, and in relation to only one aspect of the problem, the fact that some criminals are addicts, and that all addicts are forced to engage in crime in order to support their habits, should not lead to a solution based on the assumption that addicts are all necessarily criminals. That's just by way of illustration.

And, then, my last point, one final thought. There is a deep sense in which you must recognize that there is no solution to the problem of addiction. In one sense it may indeed be said that addicts are incurable. Unless and until he wants to be cured, no outside program of either punishment or treatment will solve the problem, either for the individual addict or for the community. The ultimate hope of recovery for the individual and the solution of the whole problem lies in the will and the desire of that individual. And, human nature being what it is, we must face the fact that regardless of what measures are taken, some individuals will never be reached effectively or permanently. Any proposals which you may make and which are implemented must take this hard fact into consideration.

There is also a positive truth in the statement that addicts are curable. If the will to be free of addiction is present, and given the necessary opportunity to implement that desire, then the problem is relatively simple, in view of the help that society can provide through various agencies.

That is why I must end on an emphasis of the truly spiritual nature of this grievous problem. No doubt you expect this sort of emphasis from a minister of the gospel. But we cannot fail to recognize the importance of the spirit, even in a problem such as this. To change the way of life, the spiritual foundation, the invisible element upon which all else rests, and from which everything else gets its direction, that must be the true goal, and the final aim of our efforts. Do not neglect this side of the question, dealing with this problem. Do not hesitate to involve in your deliberations and in your decisions the rightful responsibilities of the Church toward all men, and do not feel hesitant in demanding of the Church all possible assistance when, in your wisdom, you may deem them to be of such assistance.

Above all, be assured, members of this Committee, as you have approached this problem, and as you continue to investigate it, if you do so in true sincerity and in the deepest humility, none of your efforts will be in vain. You are

faced with a tremendous problem, beyond your own abilities. But I want you to know that you may be confident in the knowledge that the earnest prayers of many people closely associated with the problem will be of assistance and inspiration to you.

Thank you.

The CHAIRMAN: Reverend Blackburne, we do appreciate very much your submission and I want to assure you on behalf of the Committee that they will be given every consideration and, again, may I thank you.

To safeguard the anonymity of the next nine witnesses heard this day, Committee Counsel was directed to prepare the summary of evidence which follows.

SUMMARY BY COMMITTEE COUNSEL OF TESTIMONY GIVEN IN
CLOSED SESSION DEVOTED TO RECEIVING EVIDENCE OF
ADDICTS AND RELATIVES AND/OR FRIENDS OF ADDICTS

WITNESS No. 1.

Sister of Addict Trafficker.

Addict is now 27 years of age. Parents were separated when addict was 3 years of age. Family consisted of 2 children—1 boy and 1 girl. Addict was raised in foster home. Returned to father when 14. Difficulties began at that time. Sister is not addicted. History of early juvenile delinquency—long criminal record—association with bad companions. Addict left home when 15. Acquired drug habit at 16.

Prior to completion of a 3 year prison term, witness had provided a home, money for clothing and other essentials for use of addict on release from prison. Addict was liable to pay a fine in addition to the sentence which was expiring. The sister had money for that purpose. Sister suspects that someone in drug syndicate paid fine for addict and he was released one month earlier than contemplated by her. She complains that prison authorities should have notified her before releasing him.

WITNESS No. 2.

Father of an Addict.

Addict 43 years of age. Had no juvenile delinquency record. Became addicted when 15. Has been using drugs for 25 years. Has long criminal record and served terms at Oakalla Prison and B.C. penitentiary. Addict had good education—was good worker. Addict's wife worked to support only child who is now 21 years. Addict had treatment to break habit several times. Father became widower when boy 14—devoted much time to business. Addict acquired habit when working on freight boats. Witness complains that National Employment Office mark their cards to identify person as addict, making it difficult to obtain and keep work. Addict was working at out of town contract job and not using drugs when recognized by former guard at Oakalla, following which he was discharged.

Addict's wife worked at job handling much cash. Addict suggested pre-arranged holdup. She became nervous and had to resign her position.

WITNESS No. 3.

Father of Female Addict.

Parents divorced when child 3 weeks old. Father kept her until 8 years of age, when he remarried. Successful businessman of adequate means. Girl acquired habit at 16. Father worked most nights. Stepmother suffered from mental illness. Daughter attended good schools. Acquired habit by association with known addict.

Witness willing to pay for hospitalization and treatment but no facilities available. Daughter convicted of shoplifting and prostitution. Father suggested attractive opportunities for new life elsewhere. Addict insisted on staying near source of supply of drugs. Addict's father believes that if treatment facilities had been available, and daughter removed from Vancouver, she would be well today.

Knows that daughter created 2 new addicts, one age 16. Witness opposes narcotic clinics. Complains that there are no facilities for treatment even for those willing to pay for it. Witness recommends an addict be given 2 or 3 chances and if he or she does not respond to treatment, that he or she be permanently segregated.

WITNESS No. 4.

Addict Trafficker.

Criminal record commencing 1931, consisting of shop-breaking, breaking and entering and theft. Possessing firearms, shop lifting, possessing stolen property, etc.

Has been in prisons in British Columbia and elsewhere. Had record of delinquency before becoming addict. Addicted at 16. Seems to be confirmed addict. Comes from good home—acquired habit out of curiosity. Stole drugs from relative's drug store to begin with. Has been without drugs for four years. Cannot tell how long he will remain away from drugs.

Would remove penalties for possession of drugs—would register all addicts except medical and professional addicts. Would legalize sale of drugs to addicts. Has had some experience with "Narcotics Anonymous". Advocates narcotics clinics.

WITNESS No. 5.

Addict Past Middle Age.

Long record of crime and drug offences, not detailed. Supported habit by fraud, cashing cheques, etc. Advocates narcotic clinics for supply of maintenance doses. Suggests dosage to continue while addict working at useful occupation. Has used drugs for forty years, obtained from doctors by representing himself to be ill.

WITNESS No. 6.

Former Addict Now Gainfully Employed.

Addict had delinquency record before addiction. Used morphine then changed to heroin. Described himself as "joy popper". Has had several prison terms. Has been without drugs for four and a half years. Is convinced he will never use drugs again. Is training for entry to Communion of a church. Working steadily and completely rehabilitated. Has no craving for drugs any more. Last conviction not related to drugs but due to drinking. Finds life more meaningful without drugs. Has removed himself from drug atmosphere. States that he was never firmly addicted.

WITNESS No. 7.

Former Addict Now Well Established in Business.

Was a delinquent before acquiring habit, now married and completely rehabilitated. Member of "Alcoholics Anonymous". Home surroundings had

been unhappy. Acquired habit through association with addicts, thieves, etc. Change in life due to contact with religious group. Concerned about lack of after-care on release from prison. Suggests jail personnel had no experience in handling addicts.

Addict never deeply addicted, although has had severe withdrawal pains. Maintained habit by hotel prowling. Returned to drugs shortly after each release from jail. Found that peddlers were not looking for new customers. Has no desire to return to drugs but recommends establishment of narcotic clinics.

WITNESS No. 8.

Friend of Addicts.

Has worked with addicts as friend. Recommends establishing of hospitals for treatment of addicts,—one in British Columbia and one near Toronto. Recommends small institution for withdrawal treatment and rehabilitation. Recommends psychiatric treatment, vocational guidance and work training. Recommends close liaison between rehabilitation hospitals or centres and personnel managers in British Columbia. Would legalize the sale of drugs. States cause of addiction to be associated with other addicts. Recommends that Doctors be permitted to administer drugs. Knows fifty to seventy-five addicts now working and obtaining maintenance dosages. They support their drug habit by work though they obtain drugs through regular criminal channels.

WITNESS No. 9.

Former Addict.

Comes from broken home. No history of juvenile delinquency before acquiring habit. Habit acquired through association. Started as joy-popper. Used morphine and heroin and his regular habit was six capsules a day when he discontinued. Has also been peddler.

Has not been using drugs since 1938.

Since abstaining from drugs, has been in trouble with authorities—two offences—not related to addiction. States he knew confirmed addict who discontinued chiefly because he was afraid of conviction as an habitual criminal. Witness had been in army for several years. Believes that army life contributed to his abstaining from drugs. Although he had been exposed to drugs in line of duty as medical personnel, has not relapsed.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

OTTAWA, Wednesday, May 11, 1955.

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 8.00 p.m. Senator Reid in the Chair.

The CHAIRMAN: Honourable senators, we have a quorum. Before commencing the evening's proceedings I would like to put this on record for the information of all honourable senators including the Committee.

Invitations to make representation to the Committee were mailed to the Attorney General and the Minister of Health of each province. As honourable members are aware, the British Columbia government took an active interest in the problem, but of the three other Attorneys General and six Ministers of Health who have replied to date all have stated they have no representations to make.

The Ministers of Health of Newfoundland, Prince Edward Island, New Brunswick, Ontario, Manitoba and Alberta have replied, as well as the Attorneys General of Ontario, Saskatchewan and Alberta.

In addition to Vancouver, the mayors of Montreal, Toronto, Winnipeg, Calgary, Edmonton and Victoria were consulted. As a result, it is proposed to visit Montreal and Toronto, and we will hear Chief Constable Anthony of Edmonton today. The other cities referred to have no representations to make.

Two briefs have been received from Mr. R. S. S. Wilson, formerly Superintendent, R.C.M.P., and a man with wide experience in the narcotic drug field. As the quantity is insufficient for distribution to all members, I suggest they be printed as appendices to today's proceedings. (*See Appendices N and O.*)

I will ask the Secretary to read a letter from Chief Constable Mulligan of Vancouver, which is self-explanatory. The photographs referred to in the letter will be passed around; the criminal records mentioned are in the Secretary's custody and are available to any honourable senator who wishes to see them.

I wonder if I can have the Committee's consent, after making arrangements, to visit Toronto on the 20th and Montreal on the 27th. The mayors of both these cities are providing accommodation and making everything agreeable and suitable for us to hold a one-day sitting in each of the two cities. The day is Friday, so that, as the Senate does not sit on Fridays, we shall not be deprived of the opportunity to attend its sessions.

Senator HAYDEN: I would so move, Mr. Chairman.

Senator STAMBAUGH: I second the motion.

The CHAIRMAN: Then it is agreed that we shall visit Toronto on the 20th and Montreal on the 27th of May. If there are enough senators available, we can probably obtain a special car to take us to Toronto.

SPECIAL COMMITTEE

The ASSISTANT CHIEF CLERK then read the following letter:

"VANCOUVER CITY POLICE DEPARTMENT

Public Safety Building
312 Main St.,
Vancouver 4, B.C.

April 27, 1955

"Mr. John A. Hinds
Assistant Chief Clerk of Committees
Parliament Buildings
Ottawa, Ontario

Dear Sir:

re: Senate Special Committee on the
Traffic in Narcotic Drugs in Canada

I have mailed to you today under separate cover the criminal records of 26 persons every one of whom has been convicted of an offence under the Opium and Narcotic Drug Act, and in each case the record shows that following such a conviction, they have been convicted of a major criminal offence (indictable).

I would have liked to introduce this evidence at Vancouver and entered these records as exhibits in rebuttal of some of the statements made by other witnesses that drug addicts were a harmless type of individual and that they did not commit major crime. You will find an appendix explaining the abbreviations on the criminal record sheets.

I am also mailing photographs of nine criminal addicts in Vancouver, two photos of the one subject in each folder. I have no comment to make about them. They are merely sent for the benefit of the Committee in forming their own conclusions as to whether the change in the appearance of the same individual can be attributed to narcotic addiction, or to a combination of this and leading a dissolute life.

Faithfully yours,

(Sgd.) W. H. Mulligan
Chief Constable."

The CHAIRMAN: This material will be passed around and you can look at it. I am now going to introduce Chief of Police Anthony from Edmonton, who will tell us his experiences of the problem which is before us.

Mr. A. H. LIEFF: Might I just say that the first page of the brief is a *précis* of the long and varied experience of the witness. Probably the Committee have had an opportunity to glance at it; it is there in some detail.

BACKGROUND EXPERIENCE REGARDING ENFORCEMENT OF THE
OPIUM AND NARCOTIC DRUG ACT

Melville F. E. Anthony, Chief Constable of the City of Edmonton, Alberta.

A Constable and Corporal in the Royal North West Mounted Police—Royal Canadian Mounted Police, 1918 to November 1927, stationed at various points in Manitoba and Saskatchewan. Customs-Excise Preventive Service, November 1927 to March 31st, 1932. Stationed rural Manitoba, Winnipeg and

Calgary. For last three years of this service, a Special Investigation Officer for Western Canada. April 1932 a Detective-Sergeant Officer for Royal Canadian Mounted Police, stationed in Edmonton, in charge of enforcement of the O and ND Act, under the Divisional Officer Commanding until 1934, Sub-Division Sergeant Calgary until March, 1935.

To Winnipeg, Manitoba as Detective-Sergeant March, 1935, placed in direct charge of enforcement of the O & ND Act, amongst other duties, and so remained as Detective Staff Sergeant and Detective Inspector until August, 1945.

Transferred to Vancouver, B.C. as Officer in Charge of the Criminal Investigation Branch, with such position the responsibility of supervising enforcement of O & ND Act. May 1947 transferred to Toronto, Ontario as Superintendent and Officer Commanding the Division, again with superintendence over Narcotic Drug enforcement. May, 1951 transferred to Ottawa, Ontario as Director of Criminal Investigation and so remained until September, 1953. September, 1954 to Edmonton, Alberta as Chief Constable of the Edmonton City Police.

During the entire service, connected in one way or another with the enforcement of the Opium and Narcotic Drug Act, including time spent with Customs-Excise Preventive Service, when question of unlawful importation and possession of unlawfully imported drugs was one of the duties.

The CHAIRMAN: Will you commence, Chief Anthony? You can sit down if you want to.

Mr. MELVILLE F. E. ANTHONY (*Chief Constable of the City of Edmonton, Alberta*):

Conditions in Edmonton 1955

The conditions in Edmonton in respect to the enforcement of the Opium and Narcotic Drug Act at the present time are reasonably good. We have only about eight known addicts, with not more than one or two suspected peddlers. Heroin is the only narcotic used. The street price for a diluted grain of heroin averages between \$15.00 and \$20.00.

The present favourable condition cannot be accepted as a condition that will necessarily continue. It has been my experience that within a matter of two weeks or a month a favourable condition such as that mentioned may deteriorate to a most unfavourable situation, and if effective enforcement action is not taken, and such action supported by the courts, it will only be a matter of time until the situation gets out of hand. It is only necessary that a "source of supply" become established in a large city and by the "grape-vine" let it be known that he is so established with unlimited supplies to be sold at the right price, and addicts from across Canada will immediately congregate in that city. With sufficient demand established, the price will be raised as high as the traffic can bear.

Corrective Methods

Press reports have indicated that certain witnesses who have appeared before this honourable committee, have advocated a place of detention where addicts can be confined for an indefinite period of time, only to be released when they have been cured of their addiction and have indicated a readiness to be re-established.

I agree with such submission, but I am concerned with the form of detention, the corrective measures that may be employed during confinement, and the supervision that may be maintained upon the release of the individual. I base my concern on the fact that during my thirty-seven years as a law enforcement officer, in one way or another connected with the enforcement of the Act, I have personally been responsible for the production of evidence

that has resulted in numerous convictions and unfortunately, a number of such convictions were registered against the same individual. In other words, a person addicted to narcotics has been sentenced to the penitentiary for a lengthy term of imprisonment. Certainly on his discharge he was not addicted, and many have told me that "never again would he use narcotics". These same individuals within a matter of weeks have become re-addicted, and again have been sentenced to a term of imprisonment.

Within my experience, I have never known of an addict who was enabled to be cured of his addiction. I did know of one individual in whom I had great hopes. He was using thirty grains of morprine a day. After confinement to an institution he maintained that he would not again use narcotics. I kept this man under more or less constant supervision for about eight years, and was satisfied that he was going to prove himself to be the exception to the rule. At that time the subject reverted to the use of narcotics, and developed a habit equally as bad as that which he had before his cure and reformation. After a period of some two or three years he was able to again "break the habit". He served overseas and on his return to Canada was employed in a satisfactory manner and was not using narcotics. It has now been some years since I have had any contact with this individual, hence I cannot say as to whether he has been enabled to maintain his position without reverting to the use of narcotics. He may be the exception to the rule. In my experience he is the closest to a cured man that I have ever encountered.

On the basis that gaols have failed to cure addiction and medical science has failed, so far as I am aware, to be of much assistance in counteracting the problem of addiction, I would agree that addicts should be neutralized by confinement for an indefinite term. However, should such suggestions be adopted I would submit that work, and hard work, must accompany that confinement. The greater percentage of addicts become addicted through their own mental weakness, and if they can be cured, they should in some manner be required to pay for their cure. It would be unfortunate if an institution was provided where these persons could go for a "rest cure". It is my suggestion that when their physical condition so permits, after confinement, that they be required to work at a useful occupation. If it is necessary to teach them a trade, they should be taught, but compelled to produce results.

It is suggested that the result of their labours should be converted into a monetary credit. From this credit a stated sum should be deducted monthly to pay their upkeep and maintenance, the remainder placed to their personal credit. If competent authorities consider that an inmate has been cured of "addiction" he should be released on a form of stringent parole. Moneys held to his credit at the institution should be transferred to the custody of the parole officer, who should be authorized to make payments as and when required.

Having mentioned a parole officer, I should explain that regardless of the apparent condition of the addict upon his discharge from the institution, he should be placed on parole until such time as the authorities are satisfied beyond a reasonable doubt that the addict has become re-established in society, and that he is usefully and gainfully employed and unlikely to become re-addicted.

It is my opinion that if an institution, such as that visualized, is established, competent parole officers should be employed and given special training in the handling of former addicts. I submit it is not a police duty to act as a parole officer, and the police should not be expected to do so.

Assuming there is a system of parole, it would be expected that the parole officer would assist the former addict to obtain useful employment—in fact such employment should be available prior to the release of the individual. The "credit money" which I have suggested should only be used to assist the former addict in cases of emergency or unemployment.

It is appreciated that there might be some problem connected with the disposal of the goods manufactured or produced by the inmates of an institution—complaints of the product of prison labour being offered in competition with identical goods produced and manufactured by commercial concerns by non-prison labour. Surely, however, a market could be found that would not offend either commerce or labour. I think that any attempt at cure will fail unless the addict can regain the pride of accomplishment and ability. He must be shown that he can again occupy a position in society and be a useful citizen.

It is my opinion that any institution that may be established for this purpose would have to be located so as to be inaccessible to those drug peddlers and others who will try to muggle narcotics within the grounds or buildings, and try to maintain personal contact with their former customers. Should an institution along the lines mentioned be established, there would have to be some safeguards relative to committal. I feel, however, that a conviction through the courts should not be a condition precedent to committal. My hope would be that a procedure similar to that taken under many of the Provincial Mental Diseases Act would suffice, and that voluntary committal would be welcomed. Discharge from the institution should never be merely at the request of an inmate, or at the request of persons interceding on his behalf, but rather only after a competent committee has agreed to such dismissal. I do feel, however, that if application is made for discharge by an inmate and such application has been refused for what appears to be good and sufficient cause, the inmate, if he feels aggrieved by such refusal, should have the right to appeal to an independent body to have his case reviewed.

Drug Clinics

I have had drug addicts suggest to me that they should be permitted to have access to drugs through legitimate sources, such as clinics, etc., and that if so they could be gainfully employed and not be a burden to the State.

I understand that similar suggestions have been advanced to this committee.

I do not feel competent to express any definite opinion on this sort of representation except to say that some twenty to twenty-five years ago, in western Canada, we had what amounted to this form of a clinic. For example, in several of the larger western cities certain of the medical profession did try to assist these addicts. It was not unusual to find a doctor's waiting room occupied by twenty to thirty addicts, during a morning and an afternoon period. The addict received a narcotic injection on a reducing basis at a price range from 50 cents to one dollar. The addict who felt that he did not get a sufficiently strong injection from one physician would, of course, go to a second physician without the knowledge of the first one. While admittedly during this period it was difficult to obtain employment, I must say that I never saw an addict make a serious attempt to obtain any form of legitimate employment. Also around this period of time, one center in western Canada that wished to be free of drug addicts devised a scheme whereby an addict, upon arrival in that center, would report to the chief constable to whom he would explain that he was an addict who required narcotics and if his needs were met he would leave such center. The Chief would give him a signed "chit" to be presented to a local doctor who would, for a small fee (often gratis) give him a prescription authorizing him to purchase a tube of narcotics from a local drug store at retail price. This form of clinical operation resulted in addicts obtaining supplies, reselling at a handsome profit any that they considered as surplus to their immediate needs. Again, these fortunate addicts who had a "source of supply" by this means did not endeavour to find employment other than by selling narcotics. I should explain that this situation was rapidly corrected when it was brought to the attention of authorities at Ottawa. If the foregoing can be accepted as any criterion, I would say that the establishment of clinics would not serve to discourage addiction,

nor would it result in addicts being gainfully employed. In fact I think they would only build up a greater tolerance, and that if the dosage was not increased they would look for that extra amount in the underworld.

With this form of diversion of narcotics from the legitimate channels, one rather useful purpose was possibly served, that is to say there were little, if any, narcotic supplies smuggled into or distributed in Western Canada.

It might be added that immediately after the First World War a considerable amount of opium was used—mostly by persons of the Oriental race, this for smoking purposes. Cocaine was not a popular drug in the West and its use was confined to persons who had become addicted elsewhere than in Canada. Morphine was without question the popular drug—administration by hypodermic. In the late twenties, addicts in Winnipeg commenced using heroin and it was not long before there was no demand for morphine in that city. That form of addiction spread to other Western cities, and later to the Eastern cities. It is my experience and information that heroin is now universally the popular drug among addicts in Canada. The smoking of opium has disappeared, as has the use of cocaine. There can be no doubt but what the introduction of Mexican brown heroin during the War years greatly increased the demand and popularity of heroin.

Enforcement Problems.

If it is accepted that the sale of narcotics their illegal importation into Canada and drug addiction is a national problem—and I believe that it is—I feel justified in expressing some concern regarding the responsibility of enforcing the Opium and Narcotic Drug Act. In expressing this concern I feel that it is proper for me to make use of the knowledge that I gained while a Member of the R.C.M. Police, that which I have gained by many years association with City police departments and that which I have gained by virtue of my position as Chief Constable of Edmonton.

The O. & ND Act being Chapter 201 of the R.S. Canada 1952 is a Federal Act so worded as to permit enforcement by any peace officer. No police department or other law enforcement agency is directly charged with the responsibility of enforcement—in other words the Federal Force (R.C.M.P.), a Provincial Police Force and Municipal Police Departments presumably share equal responsibility in connection with the enforcement thereof, each within their respective jurisdiction. It therefore can happen that in one city three police departments, i.e. R.C.M. Police, Provincial and Municipal Police, can each share equal jurisdiction in respect to the Act, and, independent of the other, be enforcing the Act. This can conceivably lend itself to an instance where, for example, the R.C.M. Police independent of other police departments may have had a subject under investigation for some months at considerable expense, and possibly the investigation has reached a stage where an arrest is pending. Another police department, city or provincial might at that stage receive some form of information alleging the commission of an offence by the same suspect. Not knowing that he was under investigation by another police department, it is possible that they might take some action under the O. & N.D. Act which would be abortive, but yet which would destroy months of investigation by the other police department. Where three police departments have equal responsibilities this can be a real possibility, the only one who benefits is the offender.

Some years ago it was the policy of the R.C.M. Police, and I presume it still is, that their main responsibility in the enforcement of the Act was the "higher-ups" and those engaged internationally. The small peddler and addict was the responsibility of the local police. At the time that policy was stated no one could question the wisdom thereof. However, conditions have changed

—the operators are more shrewd, and take greater precautions, and as a general rule can only be reached by starting at the lower bracket, i.e. the addict, and working upwards through the peddler, distributor, etc.

Without fixed responsibility this can easily create a situation where the local police would be content to leave the matter to the R.C.M. Police, and the R.C.M. Police might in turn be content to leave the local situation to the local police authority. The result could be that no effective enforcement action is taken. A narcotic situation can exist for some time in any large centre without the public becoming aware of the existence. The general public are not aware of narcotic conditions, their style of life does not bring them into contact with either addicts or peddlers, hence there is seldom a public complaint. Information pertaining to narcotic offences must be sought by the police and developed by the police, and I suggest that the police must be especially trained to enable them to recognize the problem and take effective action towards suppression. This is frequently borne out by the fact that for some considerable time there have been no prosecutions at a given centre for narcotic violations—a transfer of personnel, an active informant, or the newspapers can result in numerous prosecutions within a short period of time and the facts pertaining to the prosecution or condition often indicates that a new condition has not been uncovered, but rather a well entrenched narcotic ring has been brought to light.

Again, a few years back it was no trouble to apprehend an addict in possession of narcotics. He made no great attempt to conceal the narcotics and did not resist a search of his person. At the present time it is most difficult to actually find an addict in possession of narcotics, owing to the great precautions that are taken, their method of concealment, transportation, etc. Not only is enforcement approximately 90% more difficult than it was twenty years ago, but it is much more expensive. If one wishes to develop a case under the Opium and Narcotic Drug Act a considerable amount of monies, time and effort must be expended. This is applicable to all types of cases. Parliament provides the R.C.M. Police with money for enforcement purposes, and provided the Department of National Health with funds for administration purposes. City police departments jointly share the responsibility for enforcement, and in no manner share any monies appropriated for enforcement purposes.

An example of the difficulties facing a Municipal police department is exemplified by the following instance:

A woman was arrested in Edmonton last November by members of the Edmonton City Police Detective Division, when found in possession of a quantity of narcotics, and was charged accordingly. Over my signature, but without my knowledge, a telegram was dispatched to the Chief, Division Narcotic Control, Ottawa, reading: "Arrested here today on charge illegal possession of drugs. Please advise prosecutor". The reply was directed to Chief Constable M. F. E. Anthony, over the signature or name of K. C. Hossick, and read: "Reurtel case regret am not in position to authorize retention of counsel to conduct prosecution at federal expense in other than federally initiated narcotic case.

As stated, the telegram was dispatched without my knowledge, knowing the Department would in all probability refuse the appointment of special Counsel, I would not have made the request. We were then, however, left in the position of asking the Crown Prosecutor, a provincial appointee, to conduct the prosecution, and he might well have refused to do so on the grounds that it was a Federal Statute that was violated, and he was not

obligated to prosecute such cases. Another alternative would be to: (1) withdraw the charge and have the accused released, or (2) ask the R.C.M. Police to take over the prosecution and possibly place them in an embarrassing position, (3) ask the City of Edmonton to provide special Counsel, or (4) ask permission of the Court to permit a police officer to conduct the prosecution. Fortunately the problem corrected itself by the accused entering a plea of guilty. However, I suggest this is an untenable position. It is apparent from the telegram received over the signature of Mr. Hossick that had this prosecution been initiated by a Federal department, special counsel would have been retained to prosecute. While I have no doubt that the department has some good reason for refusing special counsel in cases initiated by municipal police departments, such refusal does not encourage municipal police departments to discharge their apparent responsibilities in respect to the enforcement of the Act. The City of Edmonton, I assume in common with most other cities, does not budget in their police appropriation for the enforcement of the Opium and Narcotic Drug Act.

As mentioned before, the efficient enforcement of this Act necessitates the expenditure of a considerable amount of money, and the use of considerable well trained man-power, the employment of agents, and such like. It is my opinion that the R.C.M. Police are much better equipped to enforce this Act, in all its phases, than a municipal police department.

In recent years there has been, so far as I am aware, excellent co-operation between the R.C.M. Police and other police departments, and in consequence of this co-operation the enforcement of the Act has been efficiently conducted. This co-operation is, however, on a personal basis and there is no assurance that it will continue. Clashes of personalities have disrupted co-operation in the past, and may do so in the future.

The fact remains, however, that under the loose system which now prevails, the Chief Constable of any city is directly responsible for the enforcement of the Act, and is the official who would properly be called to account if the Act was not properly and efficiently enforced in his jurisdiction. In my considered opinion, and I am not speaking for any other Chief Constable, direct responsibility should be fixed for the enforcement of this Statute, and if this is a national issue or responsibility, I consider that the R.C.M. Police should be charged with the responsibility for enforcement of the Act throughout Canada. With that I think that the expense of enforcement should be borne entirely by the Federal Government. I cannot see why this responsibility should legally or by inference be charged to either provincial or municipal authorities. Drugs, be they legitimate or illegitimate, are imported into Canada under controls set up by the Federal Government. They are distributed and handled in Canada, in the legitimate market, by controls set up and supervised by the Federal Government; it is only when these controls fail or are violated that we have an infraction of the Opium and Narcotic Drug Act. Hence I submit that the enforcement of the Federal controls should be the responsibility of a federal organization, and not the joint responsibility of federal, provincial and municipal authorities. I am certain that all police departments would render all possible co-operation and assistance to an enforcement body charged with the specific responsibility of the Act. We well know that it is in our interest so to do. Those addicted to narcotics unfortunately are for the most part criminals of one type or another, and no police departments want gentry of this type operating in their jurisdiction.

Not as an alternative, but if the responsibility cannot be fixed as suggested, I do believe that the Federal Government should bear some of the expense of prosecution of offenders under this Act. Surely if experienced Crown Counsel are necessary in cases investigated by the R.C.M. Police, they are equally necessary in cases handled by provincial or municipal police departments.

I am not unmindful of the fact that monies advanced by the Federal Government must only be expended under proper safeguard, and I do not submit that the Federal Government should pay for enforcement expenditure of a municipal police department. It would be almost impossible to properly calculate the actual money, other than cash, expended in time, man-power, etc. I have endeavoured to point out the difficulties and would reiterate that in my opinion it would be better if the Federal Government assumed complete responsibility for the enforcement of the Act. In the meantime I feel that if Special Crown Counsel is required, and there are many reasons why there should be Special Crown Counsel, that the Federal Government could well retain and pay that official, even if they utilize Section 626 (2) (a) (iii) C.C. which reads;

“in respect to any proceedings instituted at the instance of the Government of Canada in which that Government bears the costs of prosecution”—that any fines would be remitted to that government.

The Opium and Narcotic Drug Act

The Act, as it now reads, in my opinion lends itself to the efficient prosecution of offenders, and is sufficiently severe in the punishment provided. There are, however, several matters dealing with the administration on which I might be permitted to offer comment.

I would refer to Section 10 which creates an offence if a person who, in the course of treatment, is supplied with drugs or a prescription therefor by the treating physician and who, without disclosing the fact to such physician, is supplied with drugs or a prescription therefor by another physician is guilty of an offence and liable on summary conviction to a fine not exceeding fifty dollars. This Section does not provide any alternative punishment in default of payment. I assume that the present Section 694 (2) C.C. can be utilized. However, for some reason never made clear to me, the Department instructed that under no circumstances was imprisonment to be resorted to without first referring the matter to Ottawa. Such instructions were never, to my knowledge, passed on to municipal or provincial police, and in my present position they would not be binding. I have felt that when Parliament saw fit to pass legislation, departments should not instruct that such legislation not be enforced. In the event that specific complaints are lodged with the police alleging an infraction of that Section, the police are placed in an unenviable position. The same remarks are applicable in the case of physicians, dentists and veterinary surgeons who are reported to be operating in contravention of the Act. By Departmental instruction the Law Enforcement Agency (R.C.M. Police) is prohibited from conducting an investigation without first obtaining the written consent of the department. The policy, as I recall, was that the information pertaining to the offender had to be reported through the usual channels to the department administering the Act. At times the police were never informed as to whether any action had been taken. On other occasions the department would advise that they had written to the physician or other professional man, and warned him as to his offence. Undoubtedly some accepted this form of warning, many to my recollection did not. Ultimately some were placed on the “black-list” and prohibited from the issuance of prescriptions or receiving narcotics from wholesale sources. In a very few cases the police have been instructed to make an investigation with a view to the entering of prosecution. I agree that before the danger of drug addiction became as well known as it is today, that some form of control was necessary in respect to police activities. With the present day knowledge I do not agree that the professional man should be placed in a position different than any other offender. If a professional man sells drugs to an addict for self administration,

or sells drugs to a peddler for re-sale, it is my contention that the provisions of the Act should apply and that no penal provision of the act as passed by Parliament should be nullified by departmental order. If it is not intended that they be enforced, then I suggest they should be repealed or modified.

If the Canadian authorities were fortunate enough to entirely prevent the unlawful importation of drugs into Canada, the demand by the consumer would remain. I would suggest that in the event of complete prohibition of unlawful imports, the demand would be directed to the domestic market and would be partially met by theft or narcotics from various sources and partially by the diversion of drugs from the legitimate channel to the illegitimate channel. The professional man would be faced with a great temptation, both for the profit that might be made, and through his desire to ameliorate a form of human suffering.

During my active enforcement days I found that the inspection of narcotic records as maintained by a drug store, in compliance with the Act, was a great source of information with respect to the mishandling of legitimate drugs. When one inspected the narcotic records he could note the frequency of prescriptions to the same individual, and often determine that identical prescriptions were being filled at another drug store. This indicated, as a basis for investigation, (a) that a professional man was probably dealing in narcotics, (b) that offences were committed in violation of Section 10, (c) that new addicts were in the district and had a "source of supply", and many other matters of value that might and could be linked with information obtained through other investigative sources. In addition it gave the police the opportunity of determining the amount of security given to the drugs by the drug store management and permitted the offering of suggestions as to greater security against theft, etc. In the large cities one or two members of the R.C.M. Police worked continuously on this form of inspection. These men, as a general rule, were well qualified, and at some stage attended a course of instructions as given by the Department to better qualify them for this duty.

I have been told that recently this form of inspection by the R.C.M. Police has been abandoned in the large cities, and that the work is now being done by employees of the department. While it is assumed that there will be close liaison between these inspectors and the police departments, I cannot help but feel that the law enforcement agencies have been denied a very valuable source of information, and that their problems are in no way lessened by this transfer of duties.

Mr. LIEFF: I wonder, Chief Anthony, if you would care to take a few moments to tell the committee about your experience in the city of Winnipeg where you ran into a narcotic situation when you first assumed control of enforcement in Winnipeg. What technique did you adopt and with what result?

Mr. ANTHONY: At the time mentioned, in 1935, when I was transferred to Winnipeg and placed in charge of narcotic drug enforcement there, there were a very large number of addicts, they were all using heroin, a large number of peddlers who had been entrenched for some period of time. At that time enforcement was not very difficult, not as difficult as it is now. I could put a man under cover, I could have him work with these people as much as six months gathering evidence against sellers, putting that to one side, making no arrests until the book was closed. Those charged and found guilty were all convicted, sentenced to lengthy terms of imprisonment in the penitentiary. And then another undercover man would go in working in the same way until we succeeded in convicting practically all of those who were dealing in narcotics and those who would come into the city for that purpose. The vagrancy sections

of the Criminal Code and other provisions that could be used were employed to these people were not able to become re-entrenched, they were kept off balance.

That is the only answer I have to your question.

Mr. LIEFF: I have in mind that you must have used the vagrancy sections of the Criminal Code to keep these people busy. For instance when we were in Vancouver we learned that addicts congregated in certain areas of Vancouver, one in particular, where we saw a photograph of large numbers of addicts congregating at a given place. Obviously they were not working, and they were going about their business. How would you have used the vagrancy sections of the Criminal Code, for instance, in connection with a crowd like that?

Mr. ANTHONY: Well, of course, you realize the police is only the agency that sets the machinery in motion and it depends from there on on the courts, and some courts do not look upon the vagrancy sections of the Criminal Code with the same outlook as other courts. The courts in Winnipeg interpreted the vagrancy sections I think fairly from the law enforcement point of view and fairly from the point of view of the accused. If there was evidence of offences against vagrancy sections of the Criminal Code, those suspected were charged with vagrancy and the disposition of the case was up to the court. If they were living without work, without employment, or on the avails of crime, or on the avails of prostitution they were prosecuted and if found guilty were sentenced.

Mr. LIEFF: Were you able to clear them out of Winnipeg, Mr. Anthony?

Mr. ANTHONY: Yes, I think it is still a pretty clean city.

The CHAIRMAN: You believe, Mr. Anthony, in one single agency for enforcement rather than two or three, with co-operation to be given to that single agency by other police forces.

Mr. ANTHONY: I think there must be a directive head in any such operation as this. I cannot see where and how we can run two armies both engaged against crime and yet have no overall man in charge of the common endeavours. I would place the entire resources of the Edmonton Police Department at the disposition of the Royal Canadian Mounted Police in combatting this sort of thing. I feel if I try to discharge my duties and the R.C.M.P. discharge theirs without the great co-ordination and co-operation, which presently exists any successful enforcement might conceivably fail. I think there should be a director. I am sure that as a city policeman, anyone of us would gladly work with any force. We are not looking for honour or glory, we are looking to improve Canada and conditions, and there is no question of jealousy. There is, however, the greatest danger of failure, there is a great danger of disturbing somebody else's case.

Senator HOWDEN: Mr. Anthony, at Vancouver just now they have all available policemen busy; this work is taking all of them and they will want still more men. The Chief of Police indicated to us that he would require 30 more men to be at all in control of the situation.

Mr. ANTHONY: I do not know the present situation in Vancouver, senator.

Senator HOWDEN: I am just saying that all the policemen there that can be brought together were being occupied on this drug traffic.

Mr. ANTHONY: The answer from my point of view, sir, is that if you wish to follow one addict for two weeks to obtain evidence as to a breach of the Act—it will probably take two weeks, on an eight-hour day, five-day-a-week basis—you would require five men to cover one addict; and with the present salary and wage scale it will probably cost close to a thousand dollars. There is also the fact that most police departments have their strength set on the scale of the population. Mine is set at the present time at one to seven hundred.

If I had to take five men off my strength to follow one addict or suspect peddler, I would be depriving 3,500 citizens of that police protection which they are normally entitled to.

Senator BAIRD: How actually would you work the thing out? Your local police in Edmonton police the city?

Mr. ANTHONY: Yes.

Senator BAIRD: The R.C.M.P. are outside the city?

Mr. ANTHONY: Yes.

Senator BAIRD: Would you have them go in the city to trace or track these peddlers or what have you?

Mr. ANTHONY: They are doing that now, sir, because there are certain Acts which can only be enforced by the federal authority; for instance, the Customs or the Excise Act, which only permits the laying of information by a person having the authority of a Customs or Excise officer. The same applies to the Explosives Act. The R.C.M.P. are working in all the large cities; they are working on narcotics, and working very hard. They are working in the cities because their own crime comes in from the country. If somebody commits a criminal offence within a rural jurisdiction, and that fugitive flees to the city, of course they seek him in the city; he is arrested in the city.

Senator BAIRD: In other words, they are working through the cities all the while?

Mr. ANTHONY: Right, sir.

Senator KING: I think you might clarify the situation regarding the police in Canada. In some provinces the police departments have the aid of the R.C.M.P. That is not true of Quebec or Ontario. I think Manitoba is helped by—

Mr. ANTHONY: The R.C.M.P.

Senator KING: And Alberta also, outside the cities?

Mr. ANTHONY: Every province other than Ontario and Quebec is policed by the R.C.M.P.; and in addition to the rural areas they police part of the towns, and some of the large centres.

Senator KING: They cover the rural areas, and the large cities have their own police forces.

Mr. ANTHONY: Yes, sir.

Senator KING: And the provinces pay something for that service?

Mr. ANTHONY: Yes.

Senator KING: The inspection of drug-stores and that kind of thing, who is that done by?

Mr. ANTHONY: That was done by the R.C.M.P. I understand that recently it has been changed in certain places, and that there are departmental inspectors working.

Senator KING: And you would do that, as a police officer?

Mr. ANTHONY: Yes, I did when I was actively engaged in enforcement duty.

Senator HODGES: What was the reason of the change-over? Have you any idea?

Mr. ANTHONY: No, ma'am. It happened after I left the force. Whether it was a measure of economy or not I do not know.

Mr. LIEFF: This question has been asked before: can you help us with the following proposition? Why is there so large an addict population in British Columbia?

Mr. ANTHONY: I could not say, sir. I would probably say I chased some of them there myself! They seem to like to stay there. But the first thing that explains the presence of addicts is a source of supply, because an addict will not remain where there is no source of supply. It is like honey to a bee; once the honey is out the bees flock around. I don't know whether the addicts like the climate out there.

The CHAIRMAN: Why are they charging such high prices in Edmonton when you have so few drug addicts? Fifteen to twenty dollars a diluted grain is away above the prices for it in Vancouver, where it is supposed to be very high in price.

Mr. ANTHONY: The scarcity of supply creates the price. Something that is hard to get.

Senator HODGES: Supply and demand applies there, as it does everywhere else.

Mr. ANTHONY: Very much, and it is reflected more sharply in that particular commodity than in any other I know of.

Mr. LIEFF: Is it hard to get in Edmonton?

Mr. ANTHONY: It is hard to get in Edmonton.

Senator HODGES: Apropos of what you have just said: do you think the supply is there before the addicts or the addicts before the supply? It is like the old story of the chicken and the egg.

Mr. ANTHONY: I think the addicts have a wonderful grapevine system, and must have their source of supply in most cases before they will go to a place, except when they are, to use the expression, "on the lam", and they are looking for a source of supply; and if it becomes entrenched, they will stay with that source of supply.

The CHAIRMAN: How is drug addiction increasing? Does the small seller of drugs go out, because probably he gets a rake-off on the amount of drugs he sells, and endeavour to make other addicts? We have been asking many addicts the question, and the picture I have at the moment is, by association or going to some wild party they are initiated, but the rise is so great at the coast that I have been wondering whether the small peddler does not try to make new addicts so that he can get a cut-rate or a rake-off.

Senator BAIRD: That would be good business, I should imagine, to the commercially minded.

Mr. ANTHONY: That does apply to some extent. They used to operate in this manner, that the source of supply would give the runner so many caps or decks, he sold so many and was allowed to retain, say, six out of two dozen for his commission,—which he in turn re-sold, to provide himself with some money. Generally he had to pay before he got the drugs. There would certainly be a temptation to entice other than those who are using it; but I think that most of the addicts, of those I have spoken of, it is not that they were deliberately entrapped but rather it was by association, through crime, through environment. They got in with this bunch. An example would be a number of young high-school boys, we will say; one or two of the gang start drinking, others don't, but there is a certain amount of pressure against these other boys until they take a drink. I think addiction works along the same line. They certainly are not mentally strong to start with, and it does not take too much, in my opinion, to prevail upon them to take that first injection. I think it is something like the first oyster.

Senator TURGEON: As far as you know, Chief, are there many teen-agers addicts in Alberta?

Mr. ANTHONY: No, sir. None that I know of, sir.

Mr. LIEFF: In your rather wide experience what would you think of a set-up where addicts would be withdrawn in a general hospital and then placed into small hospitals or cottages for treatment, in groups of, say, fifteen to twenty? Do you see any difficulty in this sort of set-up?

Mr. ANTHONY: I see this difficulty. In the first place I think you would have to classify your addicts so that you balanced them. For example, you could take two men of thirty years of age who are both addicted. No. 1 man may be a criminal who has been engaged in a life of crime. He may have been an expert criminal for some time. No. 2 man may have been a petty criminal who has probably engaged in shoplifting or something of that sort in order to satisfy his habit. If you put those two men together the No. 1 man, the experienced criminal, who must have more intelligence than the other, would undoubtedly influence the petty criminal so that the result would be you might turn out two experienced criminals. If you put them in hostels such as this, the security problem would be great. Narcotics are smuggled into jails and penitentiaries. There is a strong fraternal feeling amongst the drug addicts. They do not like to see their kind suffer, and if you had this sort of small domicile the security would have to be very stringent. There might also be a tendency to have this place operate as a rest home. I think they need work and hard work from the time their first suffering is over. They must be so busy nursing their hands from labour work that they are not thinking of drugs. They must produce something and show that they are the equal of other citizens. They must be made to grow something or produce something. Their pride in manhood must be brought back. Without that any treatment would fail. If they went into a place and were permitted to take it easy the cure would not be far-reaching.

Mr. LIEFF: I take it that in these things the criminal background of the drug addict has to be taken into consideration, and this would make classification rather difficult?

Mr. ANTHONY: There would be classification problems. I believe certain branches of the medical profession are able now to classify people as to their mental capacities and so on. There is no use having one strong leader amongst fourteen men who are going to follow him. If one man is too strong he should not be put in with others.

Senator HOWDEN: We have been told in definite terms that you would get nowhere in these things without isolation. I believe some members of the committee are pretty well sold on this idea of isolation so that there can be no contact at all between the addicts and the pedlars.

Mr. ANTHONY: It is absolutely necessary, sir.

Senator HOWDEN: In fact, the suggestion has been made that the addicts be put on an island where they could be treated in a hospital and then put to work in a hospital for the amount of time that a recognized medical authority would deem necessary. They would be put to work and they would, of course, receive some wages, but they would not be given their freedom until it was pretty certain they were for the time being relieved from the drug addiction. We should follow that idea up and get the views of various persons like yourself.

Mr. ANTHONY: I did not know that representation had been made, but that view is expressed in my brief but perhaps not nearly as well as you have put it, senator. If we are going to try to help these people we have to be ruthless about it. The gloves have to come off, for we are trying not only to save them from themselves but to save others and to save the country from a tremendous waste.

Senator HOWDEN: What do you think about supplying them with drugs, as you indicate has been done?

Mr. ANTHONY: I would say definitely and emphatically no.

Senator HOWDEN: Fine, thanks.

Senator TURGEON: In your brief you deal with institutions and in one place you say: "My hope would be that a procedure similar to that taken under many of the Provincial Mental Diseases Act would suffice, and that voluntary committal would be welcomed." Now, if an addict is voluntarily committed could he not come out whenever he wanted?

Mr. ANTHONY: I would say that he would have to waive all his rights in order to be committed.

Senator TURGEON: I see.

Senator HODGES: In his book on narcotic drugs Mr. Anslinger speaks out strongly against voluntary commitment. He says that this sort of thing is seldom successful and that enforced committal is far more successful. Have you any experience in respect to that?

Mr. ANTHONY: No. But it is my impression that in the United States if an addict is voluntarily committed he can demand his release at any time.

Senator HODGES: The author did not stipulate why but he said it had not been found successful.

Senator HOWDEN: Could an addict not be committed without waiving his rights?

Mr. ANTHONY: Yes, by the employment of legal procedure.

Senator BAIRD: Would you suggest that a central institution be provided and that these addicts be gathered together and put in it? Is that the idea? For instance, if there was an institution in Vancouver would you suggest that the addicts in your area be sent to it?

Mr. ANTHONY: I would be happy if that were done, sir.

Senator BAIRD: I mean to say, something like that would have to be done. You could not have institutions in every province.

Mr. ANTHONY: That is right.

Senator TURGEON: Would you put voluntary committals and enforced committals in the same institution or would you keep them separate?

Mr. ANTHONY: They would all go in together.

Senator HOWDEN: Why put them in on a voluntary basis at all? If you do that they have the right to demand their release.

Mr. ANTHONY: No sir. I say they would have to waive their rights.

Senator GERSHAW: Have most of the cases you have encountered with respect to boys and girls involved youths who have come from broken homes? Are they juvenile delinquents who have had a rather bad history?

Mr. ANTHONY: In most cases I would say yes. It has been a question of environment. To be quite frank, however, I am a police officer and I have not investigated all these cases so I would not like to make a definite statement. However, I do know the history of some and there is no doubt that environment has considerable to do with it.

Senator GERSHAW: Do you find these people subnormal mentally or a little departed from the normal?

Mr. ANTHONY: There are some who are mental, of course, sir, but certainly there are men of reasonably good intelligence who have seen the results of drug addiction and yet have started themselves. There must be a weakness there somewhere.

Senator HODGES: It might be a moral weakness and not necessarily a mental weakness.

Mr. ANTHONY: I think probably that is right, yes. The mental must break down the moral.

Senator WOODROW: Is the average seller of narcotics an addict?

Mr. ANTHONY: That would depend how high you go, sir. The top men, when you get up that high, probably are not, but the addict to support his own habit, if he gets a source of supply becomes a seller.

Senator WOODROW: What I had in mind was that it might be better to hand out punishment to the seller, if he is not an addict, because that would be a major criminal offence, and the seller who is not an addict does not have to be treated.

Senator BAIRD: He is a hard fellow to get at.

Senator WOODROW: That is the reason why I want to ask if there are many sellers that are not addicts.

Mr. ANTHONY: Yes.

Senator WOODROW: Then why not make the punishment very stiff for them?

Mr. ANTHONY: The Act provides for that.

Senator WOODROW: What about corporal punishment?

Senator HODGES: I wanted to hang them, but apparently it was thought not to be practicable.

Senator HOWDEN: What we are seeking is a feasible plan to handle this evil, and if we can we want to find out a workable means. It has been suggested that isolation is the real key in the matter, but several witnesses were totally against isolation and were in favour of having stations whereby these addicts could get their supply of the drug under the supervision of medical men, and what not, which appealed to me as being just suicidal so far as we are concerned.

Mr. ANTHONY: Well, I agree with you entirely, sir.

Senator HODGES: As I understand it, one of the main objects of isolating or segregating addicts is that, in the first place, you might have a chance of doing something for them, and in the second place, which I consider most important, if addicts create addicts, you take out of society a festering wound, or a cancer, and thus prevent the infliction of the disease on more people.

The CHAIRMAN: Yes, you cut parts of the cancer away, at least.

Senator HODGES: Well, I mean you take them away. After all if a person has diphtheria or scarlet fever, you isolate them.

Senator BAIRD: For life?

Senator HOWDEN: Yes, if necessary.

Senator HODGES: Until you find they are amenable to society.

Senator WOODROW: Your idea would be to treat them as one would treat leprosy—confine such persons to a lazaretto and immune them for life, if necessary.

Senator HODGES: Yes.

The CHAIRMAN: Are there any other questions, honourable senators? If not, on behalf of all, I thank you most sincerely for your presence here, Mr. Anthony, and for the help you have given.

Hon. SENATORS: Hear, hear.

The committee adjourned until 10:30 a.m., Tuesday, May 17, 1955.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

Ottawa, Tuesday, May 17, 1955

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 10.30 a.m. Senator Reid in the Chair.

The CHAIRMAN: Honourable senators, we have a quorum. It is half-past ten, and I think we should get started.

We have with us this morning Mr. John H. Walker of Great Britain, who has just come here from the United Nations. He is a delegate from Great Britain to the United Nations Narcotic Commission, and has kindly agreed to come here today and give us a few words regarding the British system.

Mr. A. H. LIEFF: Mr. Chairman and honourable senators, may I say that Mr. Walker has been the representative of the United Kingdom for the last four sessions, at the United Nations. He was the leader of the United Kingdom delegation to the opium conference held in New York city, in 1953, and is Assistant Secretary in the British Home Office.

Mr. JOHN H. WALKER: Mr. Chairman and honourable senators, I would like to thank your committee for the honour done me by extending this invitation to come and speak to you here in Ottawa. It is a very great pleasure to be back in your capital city, which I first saw some two years ago, and it is a great honour, by United Kingdom standards, at any rate, for civil servants to address members of the legislature. That is not the common practice back home, and to that extent it is even a greater privilege that it might be here, and one for which I am very grateful.

I have been asked to speak about the use of dangerous drugs in the United Kingdom.

Origins

The abuse of dangerous drugs occurs in the United Kingdom on a comparatively limited scale. By dangerous drugs I mean those drugs colloquially known in North America as "narcotics", namely Opium, many of its derivatives such as morphine and heroin and their synthetic analogues such as demorol and methadone, Indian hemp (marihuana) and cocaine. There are well known references in 19th century classical authors to the abuse of opiates in the United Kingdom, but Her Majesty's Government first became concerned with drug addiction as a colonial, not a domestic, problem. It was not until the first World War, when narcotics, and in particular cocaine, began to be peddled in London that special legislation (which took the form of a war-time Defence Regulation) was thought to be necessary.

Even then the regulations took the form of wartime defence regulations, that is to say, the sort of regulations we adopt in wartime, as an expedient to deal with what was thought to be a purely wartime problem.

The creation of the League of Nations, and in particular of the Opium Committee of that body, led to the widespread adoption of a number of International Conventions on the control of narcotic drugs (including the 1912 Hague Convention which the First World War made abortive for several years), and it is on the requirements of these conventions rather than on any domestic

problem that United Kingdom legislation is based. Canada of course is a party to these conventions and it therefore follows that the systems of control in our two countries are necessarily based on the same principles, despite variations in the machinery for their enforcement arising largely out of constitutional and geographical differences. It is probably true to say that the Canadian system of control is slightly more detailed than our own.

Legislation and Enforcement

The Minister responsible for the administration of the Dangerous Drugs Act 1951 in Great Britain is the Secretary of State for the Home Department (known as the Home Secretary).

He is responsible in Scotland, as well as in England and Wales, and has certain responsibilities regarding Northern Ireland. Northern Ireland is autonomous as regards internal control, but not as regards international trade. I mention this primarily to show that the control of dangerous drugs is regarded as a somewhat special matter back home. If that were not so, we would not pretend to exercise any influence north of the border. It is because the matter is considered a national problem arising out of international obligations, that the English Home Secretary—because that is what he is—does have responsibility north of the border in this limited way. There are other exceptions, but they are very few and far between. The law in Northern Ireland is virtually the same as in Great Britain. The Dangerous Drugs Branch of the Home Office is the body primarily responsible for the administration of the Dangerous Drugs Act. It consists of the Dangerous Drugs Inspectorate (the Chief Inspector, his Deputy, and three Inspectors) and an office staff engaged in the issue of licences and import and export authorizations. The branch is one of the fields of the Home Office activities for which I am responsible in the administrative field, and that is how I came to be linked with the problem.

I am not here, as you may have gathered, either as a doctor or an enforcement officer of any kind but just an ordinary bureaucrat, and to that extent I may have some limitations if you come to ask questions later.

As in Canada, the manufacture, import, export, possession, sale, supply and procuring of dangerous drugs are all strictly regulated by a system of licences and authorizations backed by inspection. A limit is imposed on the amount of drugs manufactured in order to comply with the requirements regarding estimates of the 1931 Convention for the Limitation of the Manufacture of Narcotic Drugs. In passing, the convention—as I presume you have been told already—is at the moment the key international instrument with regard to the control of manufactured narcotic drugs, and there will inevitably be further references to this in my address a little later on.

Also in compliance with this convention, manufacturers are required to make quarterly returns of raw materials and drugs received into the factory, of drugs produced, of raw materials and products disposed of, and of the quantities remaining in stock. Wholesalers are required to make annual returns of imports and exports of certain preparations containing dangerous drugs for which import and export authorizations are not required (because the proportion of the drug in the preparation is very low). Physicians and retail pharmacists are not required to make returns but they are required to keep detailed records of dangerous drug transactions and to make them available to persons authorized to inspect them.

A number of services assist in maintaining control. The Dangerous Drug Inspectorate, which I have already mentioned, is the body specifically charged with this duty but it is naturally too small to undertake all the manifold duties arising in connection with control. Its members inspect the premises of manufacturers and wholesalers and supervise the issue of licences, and import

and export authorizations. They maintain close liaison with the police and customs, and lecture to those services on dangerous drug problems; and they keep in close touch with the Regional Medical Officers of the Ministry of Health and the Department of Health for Scotland, and with the Ministry of Home Affairs in Northern Ireland. They also deal with many inquiries from doctors, pharmacists, the trade and the general public. As you may guess, this small body of five inspectors is pretty fully occupied.

The inspection of retail pharmacists' drug registers is carried out by the police, who are also responsible for the general enforcement of the law as regards criminal offences.

Her Majesty's Customs supervise lawful imports and exports of drugs and keep a sharp watch for contraband narcotics.

The Regional Medical Officers of Health inspect physicians' registers and generally advise doctors on compliance with the dangerous drugs law. They conduct inquiries on behalf of the Home Office but it is understood that they will not be asked to do this in any case where criminal proceedings seem likely.

Illicit Traffic

Illicit traffic in the United Kingdom has never been very large and for many years now has been on a small scale. Traffic in opium, which is largely confined to persons of Chinese origin, has been declining steadily since the war. The traffic in Indian hemp, i.e. marihuana, on the other hand, is almost certainly on the increase. At any rate the seizures of this drug made in 1954 were appreciably heavier than in 1953, and for the first time there were clear traces of an organized international illicit traffic in Indian hemp. Illicit production of manufactured drugs is unknown, and illicit traffic in them virtually so, except for very occasional thefts from, e.g. hospitals or research institutions. Fraudulent prescriptions are not unknown, and occasionally an addict attempts to get a supply of a drug from a doctor on false pretences.

In 1954 there were 39 seizures of opium, involving a total quantity of 29 kilograms of the drug. All of it comes from the Middle or Far East, and is smuggled in ships. Of the 26 persons convicted in respect of offences concerning opium, only two were British in the sense that they were natives of the British Isles, and these were convicted for allowing their premises to be used for the purpose of smoking opium. There was no evidence that they themselves used the drug. One Pakistani seaman was convicted for unlawful possession. All the other offenders were of Chinese origin.

In 1954, 118 kilograms of Indian hemp were seized by the Customs, as compared with 27 kilograms in 1953. The number of seizures rose from 44 in 1953 to 68 in 1954. It will be observed that the proportionate increase in the quantity of the drug seized is far greater than that in the number of seizures, the reason being that in 1954 the quantities of drug involved in each seizure tended to be much higher than in 1953. Indeed, nearly 40 per cent of the seizures in 1954 were of quantities exceeding 1 kilogram and of these a third exceeded 5 kilograms. Seizures of quantities such as these have hitherto been comparatively rare.

Over 60 per cent of the Indian hemp seized in the United Kingdom in the last five years has been found on the ships of one company whose vessels ply between Rangoon, Burma and the United Kingdom.

There were 140 convictions in respect of Indian hemp offences in 1954, the highest number so far recorded in the United Kingdom in any one year. Of these 140 persons, all but 29 were of African, West Indian or Asiatic origin. The majority (approximately 60 per cent) of the Indian hemp offences were committed in the Metropolitan Police District. I perhaps should explain that

this is the area in and around London. It extends a good deal farther than the county of London, and has a population of well over 12 million people, or nearly one-quarter of the total population. A further 25 per cent occurred in Liverpool.

For some time now the police and customs in the part principally concerned have been exercising particular vigilance with regard to Indian hemp, and there can be no doubt that the increase in the number of seizures and convictions for offences in respect of this drug is due to some extent at least to this increased vigilance. But it seems certain that there has also been some increase in the traffic itself. Indeed, as the result of vigorous activity by the police and Customs in Liverpool (hitherto the favourite port of entry), Indian hemp is now being imported through other sea ports, particularly Avonmouth and the ports of South Wales. The traffic has reached a point where it has been found possible to anticipate the movement of one or two traffickers by noting the expected time and place of arrival of steamers from Rangoon.

As has already been stated there is little evidence of any regular traffic in manufactured drugs, but there was an important seizure at London Airport in June last year of 6 kilograms of crude opium alkaloid, containing 28 per cent of anhydrous morphine. It is thought that this particular consignment was put on the wrong aeroplane, and was destined for somewhere in the Far East. We know there is considerable traffic in crude morphine in certain parts of the Far East. This was one of the points recently brought before the Seizures Committee of the United Nations Narcotics Commission. In 1954, 48 persons were convicted of offences involving manufactured drugs, 47 of these being British subjects and one an American citizen. The majority were addicts who obtained drugs unlawfully, usually by forged prescriptions or by obtaining prescriptions simultaneously from more than one doctor. Nine of them were medical practitioners, who obtained drugs for the gratification of their own addiction and a further nine were members of the medical or paramedical professions, who were convicted of technical irregularities, e.g. failure to keep drugs in a locked receptacle.

Penalties

Offences under the Dangerous Drugs Act 1951 are punishable on conviction or indictment by a fine not exceeding £1,000 (roughly \$2,800) or imprisonment for a period not exceeding 10 years, or by both such fine and imprisonment. If the conviction is summary the corresponding maxima are £150 (roughly \$420) and twelve months. If the offence related to the failure to keep proper records or to issue or dispense prescriptions in the manner prescribed, the maximum penalty is a fine of £50 (\$140) if the court is satisfied that the offence was committed through inadvertence and was not preparatory to, or committed in the course of, or in connection with, the commission, or intended commission, of any other offence against the Act.

In practice the maximum penalties are not normally awarded.

The reason is we have had no really serious cases since the war. The range of penalties imposed in 1954 was as follows:

In respect of opium offences, sentences of imprisonment ranged from 28 days to 6 months and fines from £2 to £115 (roughly \$5.60 to \$305).

In respect of Indian hemp offences, sentences of imprisonment ranged from 1 day to 3 years and fines from £1 to £125 (roughly \$2.80 to \$350).

In respect of manufactured drugs, sentences of imprisonment ranged from 6 to 12 months and fines from £3 to £100 (roughly \$8.40 to \$280). In regard to those fines, I would interject one word of warning. They are, of course, much smaller than are found in many countries, but it is important to remember that a ten-dollar fine upon a man back home hurts him a great deal harder

than a ten-dollar fine here. It is a far greater proportion of his income or earnings. So some allowance has to be made for that.

Extent of Drug Addiction

Drug addiction in the United Kingdom continues to be small, and, save in one respect, has revealed little change over the past 10 years. The practice of opium smoking, which is almost entirely confined to the Chinese, seems to be gradually dying out. Unfortunately, hemp smoking—marihuana that is—appears to be on the increase. This is largely practised by persons originating from outside the British Isles, more particularly from the West Indies, Africa and Asia. There have been, however, a few instances of persons of European descent contracting the habit of hemp smoking, and it is the possibility that this habit may spread that is causing the Government some slight concern at the present time. British conservatism in the matter of social custom is a byword, and the likelihood of Britons taking to a drug addiction of the kind practised elsewhere, which involves intravenous injection, seems very small; but hemp can be, and indeed usually is, smoked in a cigarette which looks very much like any other cigarette, and the possibility of this habit spreading is much greater since superficially it amounts to no more than the extension of a recognized and widespread social custom, particularly since it is known to be practised by a small minority of persons in the entertainment business who are sometimes found in jazz clubs or dance music clubs, where large numbers of young people congregate in an atmosphere of excitement. In these surroundings the risk that hemp smoking may catch on to some extent cannot be ignored, and behind this there is the haunting knowledge that in other countries hemp habituation only too often leads to heroin addiction.

I would not like to give a wrong impression. We are not in a state of wild alarm about it. It is just that the traffic has been up somewhat, and is presumed to be reflected in some increased use, and we do not like it. It is a habit which, if it gets hold of the youngsters, can have very deplorable results, and to that extent we are a little concerned. We have no widespread marijuana addiction in the country, and certainly have had no violent crimes resulting from the use of it, as has been the case in some other countries.

Addiction to manufactured drugs, so far as can be ascertained, remains very steady. The number of known addicts for many years has been around about 300. The number for 1954 was 317, of whom 148 were men and 169 were women. The majority of them are over 30 years of age. 72 of them are members of the medical and para-medical professions.

I think seventy of them are, in fact, doctors and only two are members of the para-medical profession. I am not positively sure about that, but it is about that number.

Drug addiction is not compulsorily notifiable in the United Kingdom and consequently these statistics necessarily indicate only those addicts known to the authorities. There is almost certainly some concealed addiction, but the Home Office is reasonably confident that this hidden addiction is small. It is the experience of enforcement officers in most countries that sooner or later a drug addict attracts the attention of the authorities, and while we consider that in an exceptional case an addict may succeed in avoiding official notice for a protracted period, this is thought to happen only rarely. It is very noticeable in the United Kingdom that when an addict is brought to the attention of the Home Office by one source, he is frequently reported quite independently by another source in a very short time. This rather confirms our view that addicts tend to attract attention to themselves.

The United Kingdom is a country whose population includes many organizations devoted to the suppression of vice and social reform. Matters like drunkenness, the sale of horror comics, prostitution and sexual perversion are

from time to time a matter of public concern revealed in Parliament, the press and the pulpit. No such concern is expressed with regard to drug addiction, and it is significant that the society which interests itself in drug addiction is small, has a high percentage of overseas members and associate members and, to judge from its journal, devotes most of its attention to alcoholism. Off hand I can only recollect two Parliamentary questions on drug addiction in five years.

From time to time, the Home Office has received confirmation of its opinion that the degree of hidden addiction is small. One of the leading physicians in the country, who lives and practises in a large provincial conurbation, asked over seventy local practitioners if they had a drug addict among their patients. None of them had. The physician himself was aware of one case in the district, which was of therapeutic origin. The Chief Constable of a provincial seaport, (a city where, if drug addiction flourished at all in the United Kingdom, it would certainly be found) in response to allegations about the existence of vice and drug addiction in the city, and in particular among seamen of Asiatic origin, conducted a most thorough enquiry and found no evidence whatever of drug addiction. An American doctor, who at one time practised in London, came over to England some three years ago to study the problem of drug addiction in the United Kingdom. The Home Office gave her the names of one or two doctors who were known to have some interest in the problems, but pointed out that there was little scope for specialization in this branch of medicine owing to lack of patients. She herself knew of a specialist, whom she proposed to see. When she finished her enquiries, she was good enough to call again at the Office and give her impressions. The specialist, on whose help she had confidently counted, had diverted his attention from drug addiction to rheumatism many years before owing to lack of patients. All the persons she had seen were in agreement that the problem of addiction was small.

There are one or two minor pointers which suggest the same conclusion. For some years the Metropolitan Police isolated the figures for dangerous drugs in respect of theft from unattended motor vehicles. This practice was discontinued because the number of cases was so small that the information was worthless. The pre-war practice of keeping statistics of all drug addicts admitted to prisons fell into partial disuse for the same reason. A recent survey of admissions to the principal prisons in Great Britain revealed that less than two dozen addicts were admitted in the two years ending December 31, 1954. The Northern Ireland prisons had not seen an addict for several years. The addicts were almost all sentenced for minor narcotic offences. The "criminal" addict, i.e. the addict who is a confirmed criminal quite apart from his drug addiction, is virtually unknown in the United Kingdom. I will refer to that class later in this address. I mention that because the term "criminal addict" is used with many widely different meanings in many countries. The idea is he is a criminal quite apart from his addiction.

Government Attitude to Drug Addicts

The Committee has already received a good deal of information about the prescription and supply of narcotics to addicts in the United Kingdom, both from the Minister of National Health and Welfare, the Honourable Paul Martin, and from Dr. G. A. Stevenson. I thought, however, that the Committee would wish me to deal with this matter in some detail, at first hand even at the risk of repetition. The policy of the United Kingdom Government with regard to drug addiction is based on the report of a departmental committee on morphine and heroin addiction drawn up in 1924. This report sets out precautions to be observed in the administration of morphine or heroin (which at that time were for all practical purposes the only manufactured drugs giving rise to addiction in the United Kingdom). This Committee discussed

the precautions to be taken in the ordinary use of drugs in medical and surgical practice, and their administration to persons who are already victims of addiction. The Committee concluded that morphine or heroin (and clearly the same arguments apply to addiction-producing drugs which have come into use since the Committee reported, including the synthetics), might properly be administered to addicts in the following circumstances:

- (a) where patients are under treatment by the gradual withdrawal method with a view to cure;
- (b) where it has been demonstrated *after a prolonged attempt at cure* that the use of the drug cannot be safely discontinued entirely on account of the severity of the withdrawal symptoms produced;
- (c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.

This advice, which is given to doctors in an appendix to a departmental memorandum as to the duties of doctors and dentists under the Dangerous Drugs Act, is still the foundation of Home Office policy. It may be noted that the advice was given at a time when far less was known about the treatment of drug addiction than has since been discovered, particularly in North America, and it may well be that some modern expert opinion would consider one or both of the second and third criteria quoted above as out of date. This is outside my competence since it is purely medical matter, and so far as the Home Office has not thought it necessary to suggest a fresh enquiry, since the scope of the problem in the United Kingdom would not justify the time, trouble and expense involved. I would, however, emphasize that this advice should be carefully read, and in particular should be read in conjunction with the explicit statement in the memorandum that "the continued supply of drugs to a patient, either direct or by prescription, solely for the gratification of addiction, is not regarded as a 'medical need' ". Considered in this light, the advice reduces to a very small number the cases in which addiction-producing narcotics may properly be prescribed for an addict otherwise than as part of withdrawal treatment. With regard to the prescription or administration of the drug as part of the gradual withdrawal method, there will, I imagine, be no disagreement. The second type of case is limited to those where a prolonged attempt at a cure has already been made and has failed, and where the use of the drug cannot, in the view of the responsible doctor, be safely discontinued entirely on account of the severity of the withdrawal symptoms produced. The obvious instance where this might occasionally happen would be where the patient was enfeebled by old age. Obviously, if a doctor considers that by using modern techniques he can safely withdraw the drug, he is under a clear obligation to do so.

It is probably the third type of case that has given rise to such misunderstanding of the so-called "British system" and I would invite Honourable Senators to read this condition with particular care and notice how extremely restrictive it is in fact. Here, too, before administration or prescription of the drug is considered permissible, there must have been a prolonged attempt at cure. It must be further demonstrated that the patient is incapable of leading a useful and relatively normal life, and further that he cannot do this without the drug. If these conditions are conscientiously applied in the light of modern medical knowledge, the number of instances where a drug may properly be administered or prescribed in a case of this sort will be very small indeed.

Moreover, the advice tendered to doctors by the Committee and included in the appendix to the Home Office document to which reference has already

been made, does not stop there. The Committee's report contains the following paragraph.

When the practitioner finds that he has lost control of the patient, or when the course of the case forces him to doubt whether the administration of the drug can, in the best interests of the patient, be completely discontinued, it will become necessary to consider whether he ought to remain in charge of the case and accept the responsibility of supplying or ordering indefinitely the drug of addiction in the minimum doses which seem necessary. The responsibility of making such a decision is obviously onerous, and both on this ground, and also for his own protection in view of the possible enquiries by the Home Office, which such continuous administration may occasion, the practitioner will be well advised to obtain a second opinion on the case.

I have no knowledge of conditions in Canada, but in the United Kingdom a doctor's right to prescribe what he thinks best for his patient in accordance with his conscience and professional judgment, is regarded as virtually sacred, and for the Government to give advice in the terms I have just quoted is most unusual, and is a clear indication of the gravity with which the departmental committee (which included a number of eminent doctors) regarded the administration of narcotics to a drug addict. This in itself should serve to refute the view widely held in parts of North America that the United Kingdom permits and even encourages the unrestricted administration of narcotics to addicts.

Lastly I would emphasize that this policy is related to a population in which, as I have already said, the "criminal" addict is virtually unknown. Our Government has never had to consider the problem of the habitual criminal who is also an addict and I cannot say what would be the view of the Secretary of State if this problem ever arose. But it is clear that existing policy would have to be reviewed in the light of different circumstances and it may not be irrelevant to note that at present addict prisoners in gaol do *not* receive narcotics.

All this is not to say that no addict in the United Kingdom ever gets a prescription for a narcotic, or a supply of the drug from a doctor, in circumstances where the prescription or the supply is not justified. This can, and on occasion, does happen. Nor are the doctors' motives necessarily improper when it does. Few doctors in the United Kingdom have any real experience of treating drug addicts, and addicts are a notoriously difficult class of patient. Sometimes it undoubtedly happens that doctors, through lack of experience, or occasionally through mistaken kindness, prescribe narcotics for an addict where the conditions laid down by the Committee cannot be said to apply. So far as possible, when such cases come to notice, we remind the doctor of his responsibility and of the views of the departmental committee, and try to persuade him to encourage his patient to accept systematic treatment. Until 1953, the Dangerous Drugs Regulations contained a provision empowering the Secretary of State to withdraw the right of a doctor to be in possession of or supply or procure dangerous drugs, if a special medical tribunal set up under the regulations so recommended. This tribunal consisted of three medical practitioners, one being nominated by the General Medical Council, one by the British Medical Association, and one by the Royal College of Physicians (the London College for cases arising in England and Wales and the Edinburgh College for cases arising in Scotland). There was also a legal assessor. This tribunal was never used in Great Britain throughout its existence, since it was nearly always found possible to deal with an erring practitioner in some other way, either by persuasion, or, more rarely, by depriving him of his authority after a conviction under the Act had been obtained.

The disappearance from the current Dangerous Drugs Regulations of 1953 of the provisions relating to the tribunal, did not mean that the body had been dissolved as an act of deliberate policy. I mention this because its disappearance has been misunderstood. The provisions disappeared simply because, when the regulations came to be consolidated in 1953, it was realized that the rules of procedure governing the conduct of cases before the tribunal were badly out of date and inappropriate by modern standards, and it was recognized that the agreement of new rules with the medical profession would take some time. These have in fact now been agreed as regards England and Wales and it is intended to restore the tribunal in that part of the United Kingdom very shortly. Incidentally, a similar tribunal exists in Northern Ireland and this has been used successfully on a number of occasions.

International Obligations

In 1931 a Convention for the Limitation of the Manufacture and the Regulation of the Distribution of Narcotic Drugs was drawn up to which both Canada and the United Kingdom are parties. This Convention requires parties to limit the quantities of drugs, manufactured or imported, to those fixed in estimates submitted by them to the Permanent Central Opium Board. The Convention expressly stipulates that "every estimate furnished . . . so far as it relates to any of the drugs required for domestic consumption in the country or territory in respect of which it is made shall be based solely on the medical and scientific requirements of that country or territory". We in the United Kingdom have always interpreted this requirement as precluding the administration of narcotics to addicts for the mere gratification of addiction. The Government of the United Kingdom felt that this obligation in the 1931 Convention was in no way incompatible with their policy based on the departmental committee report on morphine and heroin addiction quoted above.

Treatment of Drug Addiction

Subject to what has already been said about the need to avoid the mere gratification of addiction, treatment is left in the hands of the medical profession and there is no compulsion of any kind except that on occasion a court attaches to a Probation Order a condition that an offender addict shall undergo treatment in an institution.

There are no public institutions wholly devoted to the treatment of drug addiction. Addicts can secure treatment in public hospitals and a small number of private nursing homes, most of them primarily concerned with alcoholism, accept drug addicts.

There are not and never have been in the United Kingdom Drug Clinics in the sense in which this phrase is sometimes misused in North America to describe an institution where an addict may receive supplies of a drug either gratis or at a nominal charge.

Conclusion

To sum up dangerous drugs are subjected in the United Kingdom to a wide degree of control of the exacting standard demanded by the international agreements to which, in common with Canada, the United Kingdom is a Party. The indiscriminate administration of narcotics to addicts would be incompatible with those obligations and it is not now, and never has been a feature of United Kingdom policy.

Senator STAMBAUGH: Mr. Chairman, I would like to call attention to the wording on page 10, beginning with the third line, where it says:

It must be further demonstrated that the patient is incapable of leading a useful and relatively normal life.

Should that be "capable" or "incapable"?

Mr. WALKER: Incapable, without the drug.

Senator STAMBAUGH: That is, a person is incapable of leading a useful and relatively normal life?

The CHAIRMAN: You think, Senator Stambaugh, when he was reading it, he read it as "capable"?

Senator STAMBAUGH: I think so, yes.

Senator HOWDEN: I think the observation is well taken, because, as a medical practitioner for many long years, I know that a permanent addict cannot work at all without a small supply of the drug. I just know that is right.

The CHAIRMAN: The word "capable" as read by Mr. Walker should be "incapable"?

Senator HODGES: I took it to mean that it must be further demonstrated that a person is incapable of leading a useful and normal life without the drug.

Mr. WALKER: That is so.

The CHAIRMAN: Mr. Walker will explain that one point.

Mr. WALKER: I think there has been a typing error in the copies you have. The point is, a doctor has a patient before him, and he has to decide a number of things. First, he has to decide how to treat the patient. Secondly, if treating fails, he must be quite satisfied that if the patient gets the drug he can lead a useful and relatively normal life.

His ability to lead a useful and relatively normal life must depend on the administration of small doses of drugs.

Senator STAMBAUGH: You said that some have been able to withdraw?

Mr. WALKER: Oh, yes, certainly.

Senator HOWDEN: Gradually, you mean?

Mr. WALKER: Yes.

Mr. LIEFF: At the bottom of page 8, you deal with circumstances under which a doctor might administer drugs usefully and legally?

Mr. WALKER: Yes.

Mr. LIEFF: In those cases, what is the obligation on the part of the doctor to make a report to the Home Office?

Mr. WALKER: He is under no obligation at all. We have no regulations in regard to reporting.

Senator HOWDEN: Have you any provision for the incarceration of these addicts?

Mr. WALKER: Not as addicts, no. It is only if they commit a crime justifying imprisonment.

Senator HOWDEN: If an addict really desires—which is very unusual—to take treatment for his addiction, he can do so only in a hospital?

Mr. WALKER: Yes, or a nursing home.

Senator LEGER: At his own expense?

Mr. WALKER: No. An addict, like any other person who is ill, is entitled to free hospital services.

Senator HODGES: We have heard it said there are so few drug addicts in the United Kingdom. I think you have quoted a figure of "300".

Mr. WALKER: Yes.

Senator HODGES: Does that include the hemp smokers, and also people of Asiatic or Negro origin?

Mr. WALKER: It does not include the hemp smokers; it is addiction only to manufactured drugs.

Senator HODGES: That has given rise to a great deal of speculation. At nearly every meeting we have heard there are only 300 in the United Kingdom, because of your regulations, but that cannot be taken as indicative of the whole picture.

Mr. WALKER: As far as we can discover, from taking our information from a variety of sources, and checking them with informal soundings from time to time, we are satisfied we have not many more than 300 addicts to the manufactured drugs, that is, the white drugs.

As regards the opium smokers: we have no idea of the number. Judging from statistics of seizures and offences, the practice is on the decline, and it is almost entirely amongst the Chinese.

With regard to the hemp smokers; that, we think, is on the increase, because the amount of drugs seized has increased, as has also the number of people convicted.

Senator HODGES: You cannot give even a guess as to the number?

Mr. WALKER: No.

Senator McINTYRE: Does the drug addict lead a normal life?

Senator HOWDEN: He never lives a normal life.

Mr. WALKER: That is an important question, Senator. I have come across a small number of cases where the drug addict has been able to support himself and his family and keep out of trouble. If you accept that as the definition of "normal life", I have known cases where addicts have done that. For myself, I do not consider it a "normal life" at all.

Senator HOWDEN: It would be a subnormal life. He can carry on with a small amount of opium, but it is not a normal life. It is a subnormal life.

Mr. WALKER: I think in some cases—but not in all—they do succeed in not being a social burden or a social nuisance. I think that is about all that can be said about it.

The CHAIRMAN: What do you say about a case, such as we have here, where a man is leading a life of crime, and requires ten or fifteen grains of narcotics per day, and he goes to a medical man. Would the medical man supply him with what he wants?

Mr. WALKER: I cannot say, because we do not have that problem.

Senator HOWDEN: The hasheesh and marijuana habit does not cause you much concern?

Mr. WALKER: Only in this sense, that the habit is increasing. It is not a habit any government likes to see practised in its country. We do not like it to go on.

Senator HOWDEN: But it does not present anything like the severity of the symptoms which opium and its derivatives do?

Mr. WALKER: No, Senator.

Senator HODGES: May I ask another question, Mr. Walker?

Mr. WALKER: Certainly, Senator.

Senator HODGES: Would you say where a criminal addict, that is, a criminal who happens to be an addict as well, is committed to jail or prison, is he segregated from the other prisoners? Do you know?

Mr. WALKER: We do not have the "criminal addict" in the sense the honourable senator is using the words; if an addict prisoner is found to be ill, he is put in the sick bay, but he is given no narcotics, but is given sedation, and is left in the sick bay until his withdrawal is complete.

Senator HODGES: You do not segregate them during the whole time?

Mr. WALKER: No.

Senator HOWDEN: You are satisfied the degree of opium addiction is not sufficient to warrant providing for incarcerating these addicts alone?

Mr. WALKER: That is right, sir.

Mr. LIEFF: How many doctors are there in Britain, Mr. Walker?

Mr. WALKER: I thing about 40,000.

Mr. LIEFF: On the basis of one doctor reporting one addict, that would leave 300 doctors, prescribing for the addicts about whom you know.

Mr. WALKER: Yes.

Mr. LIEFF: Would that indicate that the balance of 39,700 doctors would not be treating anybody?

Mr. WALKER: I am quite certain that a vast majority of doctors in the United Kingdom have never seen a drug addict in their whole practice, except when they have had occasion to administer narcotics legitimately for some other condition, and where, in case of prolonged treatment, a person becomes addicted. Outside of that, I do not think they have ever seen a case of addiction.

Senator HOWDEN: You are saying that drug addiction does not present a serious problem in England?

Mr. WALKER: Yes.

The CHAIRMAN: How many doctors would report it to the Home Office?

Mr. WALKER: I cannot give a number, Mr. Chairman, because some may not come across a case in ten years. Some of them do, and some of them do not. The vast majority have nothing to tell us.

Mr. LIEFF: Are your doctors encouraged to treat all types of addiction?

Mr. WALKER: Yes.

Mr. LIEFF: If a doctor was to treat a vicious addict, or what you call a "criminal addict", would he necessarily have to report that?

Mr. WALKER: No.

Mr. LIEFF: A doctor can give drugs for self-administration?

Mr. WALKER: Yes, provided he is satisfied it is in the interest of the patient.

Mr. LIEFF: And if he "puts it over" on the doctor, the patient can set up a little trade of his own.

Mr. WALKER: I think sometimes that happens. You get a young, inexperienced doctor, who has never seen an addict in his life. I think sometimes the addict may get an excessive quantity, and he would probably use that to supply some of his friends; it is not necessarily trafficking in drugs in the remote sense but rather supplying it to friends.

Senator MCINTYRE: The doctor does not have to report that?

Mr. WALKER: No.

Mr. LIEFF: Mr. Walker, do you have peddlers or narcotic "pushers" in your white drug market?

Mr. WALKER: No.

Mr. LIEFF: Do you have any peddlers "pushing" marijuana, for instance?

Mr. WALKER: We think they have some form of distribution organization. Undoubtedly the drug is coming into the country, and equally undoubtedly it reaches some of the people, and that means that certain men are "pushing" the drug.

Mr. LIEFF: You think it is international traffic?

Mr. WALKER: Yes. We do not produce the drug ourselves, and it must be obtained from outside the country.

Mr. LIEFF: Is there any indication that some of the marijuana users have gone over to use heroin?

Mr. WALKER: There are some cases where we have found men who were heroin addicts who had previously smoked hemp. I do not know whether they used heroin before they smoked marijuana or not.

Mr. LIEFF: How do you explain the comparative freedom from drug addiction in the United Kingdom?

Mr. WALKER: Well, that is the \$64 question.

Senator HODGES: I am sorry, I did not hear that last question.

Mr. LIEFF: I asked how Mr. Walker would explain the comparative freedom from drug addiction in the United Kingdom.

Senator HOWDEN: He did that by giving us the type of people who he considered were bringing in these drugs.

Mr. WALKER: That is not a complete explanation. I do not know whether I can give one.

Senator HOWDEN: It is just because in England, for many, many centuries, they have been so much in the habit of controlling things generally, that they can control these drug addicts with comparative ease, which is quite contrary to conditions in the United States and in Canada.

Mr. LIEFF: Could it be that since imports are confined to sea and air traffic, that they are easier to control?

Mr. WALKER: I think that is right. As we all know, our country, like some others, is cut off from Europe by the sea, and the imports have to come through the airports, or by ship.

Mr. LIEFF: Were you going to say a word to the committee about barbituates, and whether their use is on the increase?

Mr. WALKER: I would not like to say very much, because I do not think we have very firm information. Barbituates are not controlled, the same as narcotics. They are controlled in the same way as poisons. Their use is on the increase in my opinion, and we have the impression that too many people are taking too many pills, and that has increased the use of barbituates in too many cases. I think some have been taking them in place of other methods of terminating one's life.

Mr. LIEFF: I was told by someone who was reading about it that in 1952, out of 17,000 national health prescriptions, nine per cent were for barbituates.

Mr. WALKER: I do not remember the figure, but it would not surprise me if it were true. I would accept it as being a reasonable figure.

The CHAIRMAN: In regard to the criminal cases; I wonder if the condition is the same as it was in Great Britain in the days of my youth, where they looked down upon drug addicts as being of a lower class? That is, the criminal class would have nothing to do with addicts.

Mr. WALKER: That is still true. They regard an addict as dangerous and unreliable, and if necessary, they have been known to turn him over to the police to get clear of him.

The CHAIRMAN: I notice on page 8, you say:

- (b) where it has been demonstrated after a prolonged attempt at cure that the use of the drug cannot be safely discontinued entirely on account of the severity of the withdrawal symptoms produced.

In our investigations, I think the evidence has shown that they receive what we call the "cold turkey treatment", that is, cutting them right off, and putting them in jail, and there has been an increase of sickness and deaths.

Mr. WALKER: We have never lost a prisoner yet. Whether you could do it with older people, may be a more difficult question.

Senator HOWDEN: We had one addict come before us in camera, who said as long as he was allowed to get a small amount of opium drug, he could fill a useful place in society, but if it was taken away from him, he was useless.

The CHAIRMAN: It was regarding the severity of the symptoms by cutting off the supply. In the jails they just cut them off.

Senator HOWDEN: And develop such a degree of resentment that when a man is freed he goes right back to it.

Senator LEGER: When a doctor has an addict and is treating him, and he had been taking from four to six injections a day, does he get what he asks for?

Mr. WALKER: In the way of payments?

Senator LEGER: No, in the amount of drugs.

The CHAIRMAN: Does the doctor give him the capsules for himself, or does he give him the injections?

Mr. WALKER: It depends on the circumstances. It is entirely the doctor's responsibility, and it is up to him, as far as possible, to keep control of the issue of the drugs.

Senator LEGER: Supposing he was an addict and required six capsules a day; would he have to leave his work and go to his doctor to secure the capsules?

Mr. WALKER: It depends on the doctor. If it was a certain type of treatment, he might be given it for self-administration, but the risks there are very obvious.

Senator LEGER: It is not compulsory?

Mr. WALKER: No, it is not compulsory.

The CHAIRMAN: How are the total of five inspectors able to carry on their duties with a population of 45 million, I mean the duties you have outlined this morning? They have a terrific number of duties: supervision, sale, import and export authorizations, dealing with the police and the customs, and so forth.

I was wondering how five persons could possibly adequately cover all those inspections and responsibilities.

Mr. WALKER: They are very busy men, as I have said. That is quite clear. But they can do it. The big detail of the inspections is done by the police and the medical officers of health. The number of wholesalers is comparatively small, and for the most part include highly reputable firms, whom we can be sure are not up to any criminal mischief. At worst, they may be charged with negligence, and can then be "hauled over the coals". The routine duties are conscientiously carried out, and it is not as big a job as it may appear.

Mr. LIEFF: Do the inspectors actually check the physical stocks?

Mr. WALKER: In the wholesalers' places, they can if they want to. However, they generally go by the store records, but they can look into the cupboards. The general inspection is done from the general appearance of the records and the stocks.

Senator HOWDEN: Your department is not very apprehensive of this opium drug habit?

Mr. WALKER: No, not at the moment.

Mr. LIEFF: How large a drug squad is there in the metropolitan area?

Mr. WALKER: I do not know. It is purely a police matter. It is not the custom of the police to have too many specialists, but there are man who are left on the job continuously.

Mr. LIEFF: Are there not two sergeants, and perhaps one inspector who specialize in that work?

Mr. WALKER: It would depend on what you mean by a "drug squad". The two sergeants and the inspector know a great deal about it.

The CHAIRMAN: Are there any further questions? If not, may I express the appreciation of the committee for your attendance here this morning.

We are putting on the record the fact that we received a brief from Mr. Vaille, the President of the United Nations Narcotic Commission, but there is some trouble in the translation, so we are placing it as an appendix. It is not clear at all. With your permission, we will place it as an appendix. (*See Appendix P.*)

Senator McINTYRE: I move a vote of thanks to Mr. Walker for the very important information he has given to this committee today.

Senator HODGES: I second that motion.

The CHAIRMAN: The meeting stands adjourned until 10.30 a.m., on Friday, May 20, 1955, to reconvene in the city of Toronto.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

TORONTO, Friday, May 20, 1955.

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 9:30 o'clock a.m.

Senator REID in the Chair.

The CHAIRMAN: Gentlemen and ladies; we are here on behalf of the Senate of Canada to investigate the narcotic drug problem. We have visited the city of Vancouver, and we felt it incumbent upon us to visit the city of Toronto, and, later on, the city of Montreal. We have quite an agenda. I understand the first witness to appear before us is the Assistant Commissioner, Mr. G. B. McClellan, Officer commanding "O" Division, of the Royal Canadian Mounted Police, in Toronto.

Mr. A. H. LIEFF: With your permission, Mr. Chairman, I would like to say the Commissioner has been with the Royal Canadian Mounted Police Force for 22 years. He spent two years at Vancouver, and from 1940 to 1945, he was in the Toronto area, and for the last two years has been the Officer commanding the Toronto area.

Mr. G. B. McCLELLAN (*Assistant Commissioner, Royal Canadian Mounted Police, Toronto*): This statement represents the local R.C.M. Police viewpoint of the illicit narcotic drug trade in that area of Ontario designated as "O" Division, over which the R.C.M. Police has Federal jurisdiction. This area may be described as all that portion of Ontario South and West of a line extending due North from Trenton, Ontario, to a point roughly where it bisects a line extending due East from Parry Sound, Ontario, which is on Georgian Bay. I believe you have maps.

The statement is based on the experience of Officers, N.C.O.'s and Constables of the R.C.M. Police who have been dealing directly with the illicit narcotic traffic in the area described over a number of years.

"O" Division includes the most densely populated area of Canada, containing approximately one-quarter of the population. It is a highly industrialized area and has within its borders more large cities and towns than any other part of the country.

In addition, there is a very long frontier of at least one thousand miles separated from the United States, for the most part, by the Great Lakes System but coming in direct contact with the United States at a number of points of dense population and heavy industrialization.

To name just a few of the large centres, there is the area of Metropolitan Toronto with a population of approximately 1,200,000. There is also the City of Hamilton with a population of some 260,000; Windsor with a population of 160,000; London of approximately 100,000. There are, in addition, a considerable number of other smaller cities ranging in population from 25,000 up to 60,000.

The best figures available to us also indicate that approximately 60 per cent of all immigration to Canada since 1945 is in Ontario, with something over 40 per cent of it in Greater Toronto. The population of the Province has been increasing very rapidly in recent years and it is estimated that the population of Metropolitan Toronto alone is increasing at the rate of approximately 50,000 per year.

Directly across the border from "O" Division, in the United States, and in close proximity to the border is the most highly industrialized area of the United States, containing as it does such cities as Detroit, with a population of over two millions, and such other large centres as Toledo, Cleveland, Rochester, Buffalo, Pittsburgh and others.

I think the map will show in the circle, roughly, the area to which I have referred. There is a very heavy flow of international traffic in both directions, by rail, air, and automobile. This is a very free flow of traffic in accordance with the mutual trust and understanding between the two countries. Such a situation poses many problems for both Canadian and United States Immigration and Customs Officials and it is suggested that it would be entirely undesirable, if not impossible, to establish a type of Border Control System which exists in even the most democratic Western Countries of Europe.

It would be utterly impossible to establish any system of rigid checking of traffic across the Border in either direction without completely tying up the free movement of people and goods essential to our international commerce and tourist trade. A very short study of the Ambassador Bridge and the Tunnel between Windsor and Detroit on a busy day would very quickly indicate that any attempt to make a thorough Customs search of each vehicle would result in a complete traffic tie-up for miles on both sides of the Border. The same situation applies at such other points as Niagara Falls and the Peace Bridge between Fort Erie, Ontario, and Buffalo, N.Y. If I might digress from my statement for a moment, Mr. Chairman, may I say that I was able to obtain some figures since the statement was prepared.

In 1953, crossing at Fort Erie into Canada, on July 2nd, there were 12,867 automobiles; on July 3rd, 18,309 automobiles, and on July 4th, 15,205.

Just to show that the July 4th weekend was not the only period of heavy traffic—

The CHAIRMAN: Was that for one way or two ways?

Commissioner McCLELLAN: Incoming, into Canada. On July 11th, there were 6,420 automobiles. On July 12th, 10,849, and on July 13th, 11,233 automobiles.

The capacity at Windsor is, as I understand, 1,000 automobiles per hour incoming.

Such a situation, of necessity, provides inviting prospects to certain types of smugglers, and it is obvious that the smuggling of narcotics, where such a small and easily concealed quantity demands such a high price, is not too difficult under these circumstances.

It is for these reasons we believe that any narcotics entering Canada from the United States are, at the present time, coming in through Eastern Canada for distribution throughout the rest of the country. This situation does not always prevail. In the past, narcotics have come into Canada through seaports and through other parts of the country, and this situation may change at any time, but at the present time all indications are that that portion of narcotics which enter Canada from the United States, most likely comes through the channels which have been previously mentioned.

In addition, the most affluent elements of the criminal world on the United States' side reside in an area easily accessible to the Ontario and Quebec borders and, similarly, on this side of the border. This would include most direct routes to such cities as New York and Chicago.

It should be mentioned at this time, I think, that the R.C.M. Police have been most fortunate in the quality of the co-operation which we receive from the United States Bureau of Narcotics and, in particular, the Agents of that Bureau at the border points directly across from this Division. The same may be said of our relations with other United States Border Agencies, but we are directly concerned at this time with the narcotic problem. There is a very free exchange of information and we are fortunate that we are able to contact each other freely and without difficulty.

I should like to turn now to the problem of narcotic addiction and narcotic trafficking within this Divisional area. Our most recent survey indicates approximately 400 to 450 criminal, or suspected criminal, addicts within this Divisional area. It would be safe to say that approximately 90 per cent of the narcotic addicts, traffickers and peddlers in this Division operate within the City of Toronto. With a few isolated exceptions, the remainder are located in the vicinity of Hamilton or Windsor. There is practically no problem of drug addiction in any other area of this Division.

The narcotic for sale in the illicit market is almost entirely Heroin, in identically the same manner as prevails at Vancouver and other points. Morphine addiction, which was quite prevalent during the War years, has now almost entirely disappeared. Marihuana presents almost no problem, other than a few isolated seizures from Carnival Entertainers and other transients, but there is no supply available and there is not the slightest evidence of its use in any appreciable way. At the present time the average price per one grain capsule of heroin on the street is \$6. While there is no acute shortage of illicit narcotics, the price and other information at hand, does not indicate that it is easily available.

I should like to emphasize most particularly that there is no problem of juvenile addiction in this Divisional area. From time to time rumours have circulated, and statements have been made by ill-informed persons, that narcotics were being made available to juveniles of High School age. Each of these rumours or statements has been investigated to the point of exhaustion and in no case in recent years has there been found any foundation whatsoever for the statements made. It is equally true to say that there is no indication of any attempt by the traffickers to create a market among juveniles.

The R.C.M. Police maintain in this Division a Section of the Criminal Investigation Branch directly responsible for the enforcement of the Opium and Narcotic Drug Act, and this Section is under the direct control of the Officer in Charge of Criminal Investigation. These men are stationed, in the main, at Toronto and at those other Detachments within the Division where there is a narcotic problem. I perhaps should add at this point that the N.C.O.'s in Charge of all Detachments within the Division, while not Specialists in the field, are well aware of the situation and able to bring to the attention of the Specialists any indications of the traffic in their respective areas. Those men employed full time on narcotic enforcement are almost all experienced men, with a number of years of direct field operations in this particular branch of our work.

Co-operation between the Ontario Provincial Police, the various Municipal Police Forces and ourselves is a two-way proposition. We receive full co-operation and we endeavour to provide the same co-operation to those other Police Forces. For instance, the Toronto City Police Force maintains a Detail of men employed on the enforcement of the Opium and Narcotic Drug Act, and it might be said that the Toronto City Police Drug Detail and our own Narcotic Section operate as an integrated Squad. In other words, we do not go our separate ways; we carry out our investigations together, and in such operations as surveillance of traffickers it would be hard to distinguish which particular Officer belongs to which particular Force.

I think the best example which can be given of this type of co-operation is the illustration that there have been numerous occasions on which members of the Toronto City Police Drug Detail on their day-off have come out to assist members of the R.C.M. Police Drug Section on investigations, in which their own Force was not directly involved. It makes for a very close exchange of Narcotic Intelligence. It mitigates against any duplication of effort where both Forces might otherwise be working on the same case unaware of each others interest. It makes new methods and techniques of investigation quickly available to both Forces, and it means that the Senior Officers of both Forces are at all times kept in the picture as to the situation at any given time. It has been the practice in all Narcotic Prosecutions that experienced Counsel is provided through the R.C.M. Police. Very satisfactory working arrangements are also in force with the Hamilton and Windsor City Police Forces.

In recent months we have been able to increase our actual investigational operations by the use of those members of the Force who were previously responsible for the checking of Drug Store Records. You are possibly aware that up until recently the Narcotic Records of Drug Stores were checked by the R.C.M. Police. By arrangements with the Division of Narcotic Control, these inspections are now being carried out by Inspectors of that Division.

At one time we derived considerable useful information from our check of Drug Store Records, but, mainly due to the present almost total use of heroin on the illicit market, the value of such checks to us has decreased considerably. They still, however, serve a very useful purpose in matters which are directly the responsibility of the Division of Narcotic Control. I refer to compliance with Departmental Regulations by the Medical and Pharmacy professions generally. These are matters which are of no direct concern to the Force.

Arrangements have been worked out whereby the Inspectors will provide the Force with any information they may encounter, dealing with such matters as forged prescriptions, or other violations which are properly the subject of Police action. While this new procedure is still in its early stages, it appears to be working quite satisfactorily so far.

A Table indicating the Prosecutions Entered and the Results, for both Male and Female Offenders, for the past fifteen years, has been provided for the information of the members of this Committee. (Appendix "A").

The problem of enforcement in this Division is two-fold. We are concerned with the containment and eradication of narcotic drugs within this Division. We are also directly concerned with efforts to prevent the flow of narcotics through this area to other points in Canada.

The methods used in the first-mentioned situation are very similar to those which have been described to you by other members of the Force at Vancouver and Ottawa. Our prime target is, of course, the trafficker. This work involves a number of undercover investigations in which members of the Force have gone "underground",—to use the accepted phrase,—to develop cases against traffickers. The many difficulties, and the many chances for failure, in this type of investigation were, I believe, fully described to this Committee by Sergeant Price in his appearance before the Committee in Vancouver. I need elaborate no further on what he said because the same conditions prevail here. There are recent cases here where this method was used, but as they are now before the Courts I cannot elaborate further.

In addition it might be said that we believe we have a good knowledge of the ringleaders behind the narcotic traffic in this Division. Investigations against these individuals are usually of long-term duration, require the use of a large number of experienced men, and the chances of failure are always present. It is even necessary on occasion to withhold action against lesser offenders in order to obtain the evidence required against the major trafficker.

Prosecution of the addict is usually on a charge of possession of a relatively small amount of narcotics unless, of course, he is trafficking as well. There is a discouraging lack of any feeling of finality in the prosecution of the addict. He is apprehended in the possession of a few capsules. He goes to gaol for a relatively short term. On his discharge from gaol, he is again an immediate problem. Those addicts who have been addicted for long periods of time go through a dismal run of prosecution, gaol, then back to their former habits and eventually into gaol once again.

A classic example occurred in Toronto as recently as January of this year. A drug addict released from Kingston Penitentiary after serving a sentence of two years, less time for good behaviour, took an overdose of narcotics and died the following day. Apparently his system lost its tolerance for the amount of narcotic which he had been able to assimilate prior to his incarceration. As Commissioner Nicholson stated in his report, they are "a dreary lot of parasites." They contribute nothing to society; they prey on society in conditions of degradation, filth and depravity.

I would now refer to the second part of the two-fold problem which I mentioned previously, namely, the distribution of narcotics to other places in Canada through Eastern Canada. The difficulties in preventing the smuggling of narcotics into Canada through this area have been outlined and we have satisfied ourselves that the normal Border precautions will not meet the situation. It, therefore, remains that the solution is the elimination by prosecution and stiff penitentiary sentences of the high level trafficker operating in Canada and abroad.

We attach great importance to this phase of our work. The methods of investigation involve a number of procedures which have already been mentioned. These are carried out in co-operation with other Enforcement Organizations both within Canada and in Foreign Countries. I think it would be unwise at this time to elaborate in more detail on the techniques used or the operations being carried out, in order to avoid touching on matters of some delicacy.

I have had an opportunity of reading the report submitted to this Committee by Commissioner Nicholson, and I have studied very carefully the views which he has put forward on remedial measures both for the prosecution of the trafficker and for dealing with the addict. I should like to say that those of us in this Division directly concerned with this problem subscribe fully to the points which he has made.

It seems to me that before any measure of success can be expected we must remove either the market, or the profit from this illicit trade, or both. The high profits in the illegal narcotic business are by now well known to all members of this Committee.

The removal of the market seems to me, and my associates, to be the most readily workable proposal which we have had an opportunity to study. By removal of the market I mean the isolation of the proven criminal addict. Such isolation would, of course, involve treatment and attempts at rehabilitation, and it seems to me that such efforts will be required for a long period of time in most cases. The efficacy of treatment and rehabilitation, which falls within the medical and psychiatric field, is something on which others are much more competent to express an opinion than am I.

We do know, however, from lengthy Police experience that complete withdrawal for a period of some years is insufficient, *of itself*. The almost certain return of the criminal addict to his former addiction after lengthy periods in the Penitentiary is well known to us all. Certainly isolation in any form which might be eventually approved would provide conditions of nutrition and general well-being which the criminal addict in no way enjoys to-day.

It is my personal opinion that any attempt to rehabilitate or treat the addict under the squalid conditions in which he lives is doomed to failure. The addict has no incentive to improve his lot or to rid himself of his addiction, normally speaking. I suggest that only under conditions of complete control can the atmosphere be provided under which he may work his way upwards.

There is one more aspect on the question of isolation which I feel is sometimes overlooked. Some people, well-intentioned as they may be, in their efforts to save the drug addict, sometimes overlook the fact that there is another obligation. That is the obligation to protect the public. The criminal addict preys on society. He wrests his living and the money for his addiction from the people of his community in one illegal form or another. It does seem to me that any plan for isolation must recognize that there may well come a time in many cases, where rehabilitation is obviously hopeless. I suggest respectfully that at that time the governing factor in considering how to deal further with that addict should be the protection of the public from his further depredations.

A number of representations have been made to this Committee on the question of the providing of narcotics for addicts either free or at cost. I should like to say that the unanimous opinion of the Officers of the R.C.M. Police involved in narcotic work in this Division is that such a move would be a backward one. Commissioner Nicholson pointed out the effects from a Police point of view.

Among them the most formidable obstacle to such a procedure seems to me the question of how much narcotic the addict shall be given. At the risk of repeating what has been said to you before, I feel that we would either have to accept the addict's decision as to how much narcotic he should have, or we would have to establish some form of rationing over the amount given to him. The first would create a situation in which, I suggest, the State could not allow itself on any grounds to be placed. The second one creates a situation in which he will almost certainly seek an illicit market to purchase the extra drugs which he feels he requires.

Speaking personally, I feel there is a moral ground which makes this suggestion of "free Filling Stations" indefensible. I find it difficult to accept the proposition that the State can permit itself to provide a commodity, the use of which creates an increasing appetite for more, and the end result of which is physical, mental and moral deterioration.

There are at least two practical difficulties which I might mention. We all know of the strong representations which are made from time to time against the opening of new Liquor Outlets in various parts of our cities. I wonder what the reaction of the ratepayers is going to be when it is announced that a Narcotic Distributing Centre is to be opened in their neighbourhood?

The second practical difficulty, aside from our obligations under the United Nations Charter, is that if this country becomes known as a source of low-priced narcotics, addicts will crawl on their hands and knees, if necessary, from the far corners of the earth, to get in on the supply.

I should like to conclude my remarks with a reference to the effect of recent amendments to the Opium and Narcotic Drug Act on our work in this Division.

Senator HODGES: What are those sections? Is it a new section?

Commissioner McCLELLAN: I believe that is the section—

Senator HODGES: If they could be read into the record, it might be helpful.

Commissioner McCLELLAN: This is the one which deals with the offences of "traffic" and "sale", and it reads:

"Every person who traffics in any drug or any substance represented or held out by such person to be a drug, or who has in his possession, any drug for the purpose of trafficking, is guilty of an offence, and liable

upon conviction, upon indictment, to imprisonment for a term not exceeding fourteen years, and in addition, at the discretion of the Judge, to be whipped."

The CHAIRMAN: Will you proceed, Commissioner?

Commissioner McCLELLAN: This statement represents the local Royal Canadian Mounted Police viewpoint of the illicit narcotic trade.

Our initial experience with the new Section 4(3) (a) and (b) indicates that it will be an effective weapon against the trafficker. We have had four successful prosecutions under this Section resulting in sentences from four to ten years. Four other cases are presently awaiting trial. Such sentences have effectively removed important traffickers from the business for long periods of time.

We also feel that the risk of these heavier sentences provided in the new Section will render very unattractive a practice resorted to by criminals at times in the past. I refer to the practice in which a number of arrests were made from one seizure of narcotics, and in which one minor member of the organization came before the Courts and accepted full responsibility for ownership. He then served a term under the other Sections, with the promise of financial support from the leaders of his organization. This could be a much more costly practice in the future.

Thank you, Mr. Chairman, and honourable Senators.

As Appendix P I have a table of the number of prosecutions entered yearly for the period January 1st, 1940, to December 31st, 1954. (*See Appendix Q.*)

Senator HODGES: I would like to ask the witness a question. I was very much interested in hearing, in the first place, that he had been for two years in Vancouver. Can he suggest any reason why a city like Vancouver should have over 1,000 addicts, yet in this huge territory in the east, over which you have jurisdiction, there only 400 or 410 addicts? Can you give any reason?

Commissioner McCLELLAN: Madam Senator, I have been puzzled about that myself. It has been some considerable time since I was in Vancouver, but I keep abreast of the reports, but, naturally, I have no recent knowledge of the situation.

The only thought I have had on it—and perhaps it is a most inadequate one—is the question of climate. We are told that narcotics are easily available. Other than that, I do not think at this distance, and considering the number of years I have been away from there, that I am capable of expressing an opinion.

Senator HODGES: You think drugs are more easily obtainable?

Commissioner McCLELLAN: That is what I have been told.

Senator HODGES: Have you any reason why that should be, when you have this enormous territory along the border in this part of the country? I know you cannot give a specific answer, but have you any ideas on the subject?

Commissioner McCLELLAN: No, nothing definite. It is something we have discussed many, many times here. It puzzles us as to why it should be that way, and we have listened to the suggestion that the milder climate, which suggestion, appeals to me. That, however, is my own opinion. I am quite satisfied, however, that is not the entire answer. Drugs are certainly available, and there may be conditions there which we have not here.

Speaking at a great distance at which we are away from the situation, the problem which we are not able to resolve in our minds is that the market is there, and that is why the drugs go there, or, does the market follow the drugs.

Senator HODGES: The climate is a factor on the market.

Commissioner McCLELLAN: I think Chief Mulligan raised that in his brief. I would certainly subscribe to the question of climate, not only from the drug point of view, but, as is well known, when times become difficult in the country, I think the Pacific Coast is the first to suffer from the unemployment problem, due to the number of people who come in, because living is easier.

Senator HOWDEN: Could it not be that Vancouver is in the pioneer state—it is a new state—and you have not had time to get things as well grounded as you have here?

Commissioner McCLELLAN: I do not know. The same situation applies in many parts of the Prairie Provinces without, of course, the publicity.

Perhaps the fact that it is, in some ways, still a frontier country, combined with the large population, may have something to do with it. But you do not notice it elsewhere in the newer sections of the country.

For instance, in the northern part of this province, which has developed very rapidly, we have no indication that any problem is developing. Mind you, we do not have cities the size of Vancouver, and those two factors combined may have some bearing on it. Certainly the population—and I want to phrase this correctly—is more restless, and there is more moving around.

Senator HODGES: And less well controlled.

Senator HOWDEN: With the large number of alcoholics, would the same conditions apply, as in connection with the narcotic drugs?

Commissioner McCLELLAN: There is one situation which I have not come across in any other place in Canada, and that is the tremendous amount of seasonal work, for instance, lumbering, which is seasonal. They have the dry season, when the lumber camps are closed, and the men come into Vancouver in large numbers. It was the same in my day, in regard to hop and apple picking, and agricultural work. I do not know of any other place in Canada, to my knowledge, where you have the annual influx at different seasons, and where you have the transients who come in to spend the money they have made in the woods, and then go out again. You have quite a flow of people who are restless.

The CHAIRMAN: I do not think that provides the complete answer, because statements have been made to us that drugs come in from the west to the east. You have said this morning how impossible it would be to know what drugs are going from the west to the east, as it is to know the drugs going from the east to the west. The statement has been made in Vancouver that drugs come from the east, and you have said how impossible it is to check a great number of cars crossing the boundary.

But, if the drugs do come in through here, why do they not stay here? They are going to the west, almost immediately. I do not know that it is proof, by simply making that statement. I do not know how it could be.

Commissioner McCLELLAN: Of course, portions of the drugs do stay here, a portion of them for our own addict population. The rest are going elsewhere. I suggest that at the present time, because of the fact that a great deal of our narcotic drugs come from the United States, and here is possibly the easiest border for them to get across, due to the very large traffic movement which I have mentioned.

The CHAIRMAN: What checks do you make here?

Commissioner McCLELLAN: We, of course, work very closely with the Customs. They are doing all they can. We feel, as I think I have mentioned, that a proper check is not the answer, although it is, partly.

We try to penetrate the organization. I think, if I can give it as shortly as possible, that we must know who has it, where it is coming from, where it leaves, and so forth, and, on the other hand, we must know who is going to receive it on this end, if we are going to have any success.

Senator HODGES: I would like to ask the Commissioner another question. Do you find the drug addicts associated with the more violent types of crime, or do they mostly come within the terms of shoplifting, prostitution, and so forth, as we have been told in other places.

Commissioner McCLELLAN: The criminal addict?

Senator HODGES: Yes, that is what we call the "criminal addict".

Commissioner McCLELLAN: Our experience has been in recent years that the addict is not usually involved in the more violent crimes.

Senator HODGES: For instance, bank holdups, and crimes of that nature?

Commissioner McCLELLAN: I think Chief Chisholm can answer that better than I. But I think I can safely say that they are most shoplifters, and prostitutes, and, as a rule, in this area they are not bank robbers, and those committing other violent crimes. They are mostly thieves.

Senator GERSHAW: May I refer to a statement you have made on page 9 of your brief, where you say:

In addition it might be said that we believe we have a good knowledge of the ringleaders behind the narcotic traffic in this Division. Investigations against these individuals are usually of long-term duration, require the use of a large number of experienced men, and the chances of failure are always present. It is even necessary on occasion to withhold action against the lesser offenders in order to obtain the evidence required against the major trafficker.

Are the police hampered in their attempts to trap these ringleaders? What seems to be the great difficulty in obtaining convictions against them?

Commissioner McCLELLAN: One of the difficulties is the ringleader never handles the stuff himself. That leaves you in the position of pretty well having to develop a conspiracy, and show that he was in it financially or in some other way. They are most careful not to handle the drug themselves.

Conspiracies take a long time to develop, and we are hampered by the difficulty in tying the ringleader—I am speaking of the top man—in with the actual distribution of that particular product, and the very, very, careful security measures which are adopted by the top people in the narcotic drug traffic. It is a proposition of long, hard, tedious investigation, requiring night and day work for months on end, and requiring the very best men we have with very frequently no such thing as days off, or time to themselves.

Senator HORNER: These ringleaders which, in most cases, are not drug addicts, or, very seldom?

Commissioner McCLELLAN: The top leaders practically never.

Senator HAYDEN: How did you arrive at the census of criminal drug addicts?

Commissioner McCLELLAN: The census was prepared, Senator, before I came here, partly by going over police records for a number of years, checking the arrests which had been made eventually of all well-known criminal addicts who had been arrested at one time or another.

Senator HAYDEN: The market for drugs must be greater than the 400 known criminal addicts you have mentioned.

Commissioner McCLELLAN: I do not think so, sir.

Senator HAYDEN: Then isolation is the obvious answer, because in any one of these years—in the last eight years—you have convicted well over 100 people, and at that rate it would not take long to remove the whole market.

Commissioner McCLELLAN: I should say that of these 400-odd, there are practically 100 in jail at most times. About 25 per cent are usually in jail at any time.

Senator HAYDEN: What amazes me is your statement that the market for these drugs—heroin—simply gives a number of 400 known addicts.

Commissioner McCLELLAN: That is the local market in our Division.

Senator HAYDEN: There is no place else in your Division, except the places you have mentioned, where there is noticed much of it?

Commissioner McCLELLAN: That is right.

Senator HAYDEN: So I am taking the area under your jurisdiction, and you say "400" —

Commissioner McCLELLAN: That is the addict population, as closely as we can figure it, that is, from 400 to 412. There is some variation, but not noticeably to a great extent. So far as we can ascertain, that is our market.

Senator HAYDEN: If we had a proper law with respect to isolation, we could remove the market in perhaps six months.

Commissioner McCLELLAN: It would certainly improve it very shortly.

Senator HAYDEN: You simply would apprehend them and isolate them, and keep them isolated for an indefinite period, and this market is gone, and you could deal with others as they come in, in the same manner.

Commissioner McCLELLAN: I think it would certainly kill the market, as far as the Division is concerned.

Senator HORNER: On the other hand, you must have people who are professional people, and are wealthy, and can afford to buy it? They do not need to become criminals to secure the drug. There may be others who never come in contact with the police.

Commissioner McCLELLAN: That is right..

Senator HORNER: You must have a number of them.

Commissioner McCLELLAN: Yes.

Senator TURGEON: You say that 25 per cent are in jail practically all the time? Would that not, in itself, reduce the market by at least 50 per cent in a very short period of time? Would not a longer period of imprisonment completely eliminate the market in a short time, if the market is no larger than you say.

Commissioner McCLELLAN: If you could get them all at the same time, Senator, for that period of time, yes.

Senator TURGEON: If there is always the number you mentioned in jail, there must be an accumulation from time to time, some whose terms have not been finished and others coming in.

Commissioner McCLELLAN: They rotate, that is right.

Senator HAYDEN: They overlap?

Commissioner McCLELLAN: Yes.

Senator TURGEON: Would a longer term lessen that difficulty?

Commissioner McCLELLAN: You mean imprisonment, alone?

Senator TURGEON: Yes. Would it not reduce the market?

Commissioner McCLELLAN: It would reduce the market to some extent, but I do not think that imprisonment alone will give us any final result.

Senator HAYDEN: Only indefinite isolation is the answer?

Commissioner McCLELLAN: That is right.

Senator STAMBAUGH: I would like to ask you, Commissioner McClellan, about the checking of the drug stores. I think that is done by the Department of National Health and Welfare investigators.

Commissioner McCLELLAN: Yes.

Senator STAMBAUGH: Was that instigated because the Royal Canadian Mounted Police recommended it, or are you in favour of it? Do you think it is an improvement over your own?

Commissioner McCLELLAN: Yes. How that was brought about, I do not know, because it was done at Headquarters. I certainly am in favour of it.

Senator STAMBAUGH: You are in favour of it?

Commissioner McCLELLAN: Yes. I think we can put the men who are employed on that work at this time on more useful work of actually investigating, without checking drugstore records.

As I mentioned in my statement, there was a time, particularly during the period of the war, when there were drugs, such as morphine, more widely used, and these records were of use to us. Today, the market is practically all heroin, which is illegally brought in, and these records no longer give us much useful information, from a police point of view. I am not saying they are not valuable to the Department of Health and Welfare, but from the police point of view, we have not had too much benefit from them in recent years.

The new plan by which the Department checks the records provides that we keep in touch with them, and should they come across anything which looks like a police problem, we will be advised of it, as soon as possible.

Senator TURGEON: You really think it is an improvement?

Commissioner McCLELLAN: Yes, I do.

The CHAIRMAN: How much staff have you devoted to narcotics?

Commissioner McCLELLAN: There is nothing rigid about it. We have on the strength in this city, from eight to ten men, full-time.

Senator HODGES: Just on narcotics?

Commissioner McCLELLAN: Yes, just on narcotics. That is, full-time. We have smaller numbers in cities like Hamilton and Windsor.

But that, in itself, is not a true picture, because by this time tomorrow morning, there may be 25 men engaged on narcotics, depending on what cases we are on at the time.

We bring in from other sections of our criminal investigation work, certain men, who come in and work with the drug squad themselves. If things are quiet, we may have from eight to ten men, but if there is an important case on, we may have 20 or 25. But our normal strength in this city is from eight to ten, supplementing that—as we frequently do—up to 20 to 25 on drugs.

Senator HOWDEN: The purpose of this Committee is to eradicate the drug evil. That is the reason we were assembled at Ottawa. We have had, on several occasions, suggestions which were thought to be the best plan; would you tell us what, in your opinion, is necessary to stamp out this drug question?

Commissioner McCLELLAN: As a citizen?

Senator HOWDEN: As a policeman and citizen, what procedure would you take, if it was in your own hands?

Commissioner McCLELLAN: Complete isolation first.

Senator HOWDEN: That is what we want.

Commissioner McCLELLAN: With rehabilitation and all that goes with it, certainly complete and compulsory isolation.

Senator TURGEON: Would that include the giving of drugs for a certain period of time?

Commissioner McCLELLAN: No, sir. The rehabilitation is something upon which I do not feel competent to speak, but certainly, I think isolation—whatever else you do—will never be successful if you leave him live where he lived normally, and try to rehabilitate him there.

Senator HOWDEN: You have to keep some control over him?

Commissioner McCLELLAN: You have to keep him under your thumb.

Senator HODGES: I was interested in hearing you say you have no juvenile problem. What is the average age of the criminal addict?

Commissioner McCLELLAN: I think I have some figures on that. (Referring to document). It is between 20 and 30, in this Division.

Senator HODGES: That is the average age?

Commissioner McCLELLAN: That is the average age. I may say that has been going down somewhat over the years, but certainly not at the rate of acceleration about which I think you heard in Vancouver. We have had them over forty, and perhaps more a few years ago than we have now, but between twenty and thirty is the average age.

Senator HODGES: Do you find in your experience that addicts create addicts?

Commissioner McCLELLAN: Yes. In most cases of addiction, of which I know personally they have resulted from association, first, and the non-addict being introduced to the drug by an addict.

Senator GERSHAW: Have you any figures as to the length of life of these people? Do they live long, or die early?

Commissioner McCLELLAN: No. I have no figures on that.

Senator HAYDEN: Could you apportion that 400 over your Division? How many in Toronto, for instance?

Commissioner McCLELLAN: 90 per cent.

Senator HAYDEN: You mentioned Hamilton. How many in Hamilton?

Commissioner McCLELLAN: I do not know that I have that figure. Speaking from memory, I would think from 30 to 50.

Senator HAYDEN: And Windsor?

Commissioner McCLELLAN: Whatever is left.

Senator HODGES: I am sorry, Commissioner, I did not hear your last answer.

Commissioner McCLELLAN: I said whatever is left.

Senator HOWDEN: Commissioner McClellan, in regard to the method by which you approach these drug addicts; do you keep them travelling, or do they stay pretty well in the area where they ordinarily live?

Commissioner McCLELLAN: If the supply is fairly stable, the majority of them will stay in their own particular area. We have got a floating population. If there is a panic, let us say, in Hamilton—and by “panic” I mean in short supply—we will have them up from Hamilton, until the supply eases there.

There have been times in the past when there has been a panic here, and they headed for Hamilton or Windsor, or wherever they can get it.

Senator HAYDEN: On the question of economics; you say 250 in Toronto, 50 in Hamilton and the same in Windsor; is not the simple thing just to remove them from the active population?

Commissioner McCLELLAN: That is right.

Mr. LIEFF: Do you use the vagrancy section of the Criminal Code to keep these people “on the run”?

Commissioner McCLELLAN: Not usually ourselves. The enforcement of that provision, with certain exceptions, is the responsibility of the provinces and municipalities. We do not touch it.

Senator LEGER: Do they live in one area, and stay there, or are they spread over a wider area?

Commissioner McCLELLAN: As a rule, they stay in a general area in the city.

Senator LEGER: The figures shown in your Appendix comprise only your territory?

Commissioner McCLELLAN: That is right.

The CHAIRMAN: Are there any other questions honourable Senators want to ask the witness? (No response). If not, Commissioner McClellan, may I thank you most sincerely for coming down and speaking to us today.

Commissioner McCLELLAN: Thank you, sir.

—Commissioner McClellan retired.

The CHAIRMAN: Our next witness is Mr. John Chisholm, the Chief Constable of the City of Toronto. I will ask him to kindly step forward now.

JOHN CHISHOLM (*Chief Constable, Toronto*):

The CHAIRMAN: Will you just proceed, Chief Chisholm, in your own way.

Chief Constable CHISHOLM: Mr. Chairman, and members of the Senate Committee. This morning I received a telegram from His Worship, Mayor Phillips, who is in New York, and is unable to be here today, and he asked me to extend his greetings and compliments to you, and hopes I shall be of some assistance to you, by making this presentation.

Some weeks ago I was advised by His Worship Mayor Nathan Phillips, Q.C., of Toronto, that I might attend one of the hearings of this Special Committee of the Senate on Narcotic Drugs, and I was under the impression that the hearing would be held in Ottawa. Following advice that the Officer Commanding, "O" Division, Royal Canadian Mounted Police, was attending, I suggested to His Worship that that official might well speak on my behalf, as he has definite knowledge of the narcotic drug problem in Toronto, Southern Ontario and, in fact, the entire jurisdiction of "O" Division of that Force. However, now that the Special Committee is conducting a hearing in Toronto today, I have been asked to attend, and I appreciate the opportunity of expressing my opinions.

It so happens that I am a member of the Committee on Drug Addiction of The Welfare Council of Toronto, but I should like to point out that I am not speaking at this hearing on behalf of that body, which will make its representations to your Committee independently. I assure you that the members of that committee are well qualified to express opinions on the subject of drug addiction.

If I appear to be vague in expressing opinion, or in submitting recommendations regarding this important problem, I assure you that it is not intentional. If such an attitude appears to exist on my part, I shall have to attribute it to experience. I was not in the law enforcement profession very long before I was thoroughly convinced that I knew all about the causes of crime and particularly confident that I knew all about the cure and prevention of crime, but now, after some thirty-five years' Police experience, I am not too sure that I know all the answers yet!

I have no intention of minimizing the existence of the narcotic drug traffic, nor to claim that it is completely under control. In the main, the narcotic drug problem is encountered in cities on a per capita basis, but there are, of course, exceptions to this. I shall not express opinions regarding other localities, because I am not sufficiently well acquainted with this problem outside my particular jurisdiction.

Over thirty years ago the Royal Canadian Mounted Police and Toronto Police operated almost independently in the enforcement of the Opium and Narcotic Drug Act, and offences at that time fell into two categories, viz; opium smoking (then confined principally to Orientals) and cocaine addiction. Today the picture has radically changed; we practically no longer encounter the opium, morphine or cocaine addict in Toronto—most of our “clients” being heroin addicts. The drug, marijuana, presents no problem in Toronto—I can say that very definitely, and I am very pleased to say it—and drug addiction by juveniles—or, for that matter, by teen-agers—has not been encountered. That is not just my personal view; it is also the expressed opinion of the R.C.M. Police and Juvenile Court authorities.

I view the narcotic drug problem in four phases:

- (1) the smuggling of narcotic drugs into Canada;
- (2) the transporting of these drugs within Canada to distribution points;
- (3) the distribution of the drugs locally by agents or “pushers”;
- (4) and then, the Addict, who is generally compelled to resort to thievery, or some other form of crime, in order to finance his purchase of drugs.

The responsibility in regard to the smuggling and transporting of narcotic drugs properly belongs to the federal authorities, hence the extensive work of the Royal Canadian Mounted Police. Excellent co-operation exists between the local R.C.M. Police of “O” Division, Toronto, and the Toronto Police in the enforcement of the Opium and Narcotic Drug Act. This joint operation prevents duplication and minimizes the possibility of confliction in enforcement, especially when major cases are being developed. We have found this system, which has been in vogue for a number of years, to be the most satisfactory, and conviction of major operators has resulted.

Toronto has its share of crime—one must expect that in any large city—but I will not go so far as to say that major crime in Toronto can be attributed to narcotics, but, however, it does play an important part. In our opinion most of the female criminal addicts are limited to shoplifting (or “boosting”, as they describe it) and prostitution, whereas the males indulge in shoplifting, petty thievery, thefts from automobiles, and sometimes commit housebreakings.

I understand your Committee has statistics which indicate the number of criminal drug addicts in Ontario to be 655. Sometimes the question is asked, “How many are there in Toronto?”. An estimate is all that can be given, but addicts in custody must be included in that estimate. (*See Appendix R.*) After studying our records carefully, and reviewing the matter at length with members of the Royal Canadian Mounted Police and my Department, we estimate that, including those in custody, the number of criminal drug addicts in Toronto might be in the neighbourhood of 400. A large city generally has its own quota of local drug addicts and has also to deal with a percentage of transient ones. City residence becomes almost compulsory for the drug addict, because that is where the retail market operates and the greatest opportunities for “easy money” exist.

Sometimes the Police are criticized for advocating incarceration of offenders who are addicts, but this is for certain definite reasons.

- (1) The addict is a potential lawbreaker and society is at least temporarily protected from his criminal activities by his imprisonment;
- (2) His confinement is intended to be a deterrent, but there is, of course, divergence of opinion in this regard;

(3) Perhaps most important of all, the addict's incarceration should furnish the best opportunity for treatment. Treatment of the addict while in custody is not in my province, but I am certain there will be no lack of suggestions to this Committee by well-qualified persons as to how present facilities for treatment might be improved.

In some quarters it has been suggested that addicts should be supplied with drugs, and as far as possible left to carry on their trade or occupation in the hope that, being removed from institutional atmosphere and influence, they are more likely to be rehabilitated. I assume this would necessitate the addict calling at some local clinic to have the drug administered. It could hardly be turned over to him, otherwise there would be a strong temptation to sell the drug, and non-addicts might attempt by misrepresentation to secure the drug for resale. On the other hand, the medical practitioner might consider the prescribed dosage adequate—but the addict, because of his physical condition and mental attitude, might decide otherwise, and resort to augmentation from illicit sources.

I am not suggesting that a large percentage of addicts do not wish to be cured or rehabilitated, but the question is, how can this best be accomplished? Professional men of experience tell us that free or cost-price distribution for addicts was experimented with as far back as the twenties, but apparently it failed.

I am often asked what facilities are available if a narcotic drug addict should approach the Police, stating that he is an addict and requires treatment. This is a rare occurrence, but sometimes we are approached by the parents or friends of an addict, and we can then only advise how they may proceed under The Mental Hospitals Act of Ontario, which provides for the admission of drug addicts as habitués to a mental institution or hospital on the following bases:

- (a) voluntary admission;
- (b) admission on a judge's order;
- (c) temporary commitment by certification of two physicians.

The periods of detention, of course, vary according to the mode of committal. In practice, however, the assistance of The John Howard Society of Ontario would be sought if the addict was of the criminal type.

It is hoped that recent amendments, which provide for more severe penalties, especially for the traffickers, may tend to curb the distribution of narcotic drugs. Unfortunately, we will still have the narcotic drug addict with us and his treatment while in custody and some type of supervised after-care when he has been discharged from a correctional institution appears imperative, as well as further continued research and study of this dangerous social problem. All these endeavours, however, must be supported by vigorous enforcement of the Opium and Narcotic Drug Act by federal, provincial and municipal authorities.

You will note at the bottom of the table, are the words:

"Male offenders range in age from 19 to 77 years."

We have not many in the 70-year bracket, the average being about 40 years.

The female offenders range in age from 18 to 65.

Mr. LIEFF: Chief Constable Chisholm, do you know of any case where drug addicts were actually committed under a voluntary admission plan, or judge's order or certificate?

Chief Constable CHISHOLM: I believe there have been a few, some to private sanatoria, and some to Ontario mental hospitals.

Mr. LIEFF: But not very many?

Chief Constable CHISHOLM: No, the number is small, as far as I know.

Senator HODGES: You also mentioned the "400".

Chief Constable CHISHOLM: Yes.

Senator HODGES: How has that figure been ascertained?

Chief Constable CHISHOLM: By working it out on a proportional basis, from the 655 grand total. That means the whole of Ontario, I presume.

I got my Criminal Identification office to make a search of the records, forgetting all about repeaters, and disregarding the number of charges, and I asked them to start with January 1st, 1949, down to April 20th—I think it was—and tell me the number of persons who had been charged—persons only; even though they had been in three or four times, and then next to compile the results of the prosecutions known to be connected with the drug traffic.

One might say that will not give a complete picture, because a person might be brought in and charged with some conspiracy, and some might have evaded arrest by police. That gave us, I think, the figure of 389.

Senator HODGES: You began your records in 1944?

Chief Constable CHISHOLM: From 1949 to April 20th of this year, which showed 389 persons passed through the Toronto police hands. Most of them were Royal Canadian Mounted Police cases.

Senator HODGES: The reason I asked you that is because I have received so many allegations that each and every drug addict creates four more, and those four go out and create sixteen, and so forth, and they do not seem to be justified if over a period of years, you have only around 400. I wonder if you found that each drug addict creates four more, on the average?

Chief Constable CHISHOLM: I have not the figures, but looking into the prosecutions, and speaking from police experience, I think it has increased, but has not increased by leaps and bounds at any stage, as seems to have been the impression in some quarters.

Senator HODGES: Do you think these 400 addicts are capable of being gathered up and isolated? Would you suggest that?

Chief Constable CHISHOLM: The reason I do not recommend that is this: it is hard enough for us to "sell" the idea that hold-up men who commit major crimes, be incarcerated for long terms, and I think it would be very hard to "sell" to the Government the idea that you should incarcerate drug addicts indefinitely.

Senator HODGES: Do you think it is possible to cure these drug addicts in any other way?

Chief Constable CHISHOLM: They have to be isolated, but, as I mentioned in my recommendations, there should be some sort of after-care.

Senator HODGES: Oh, naturally.

Chief Constable CHISHOLM: I cannot go on record and say that I am in favour—

Senator HODGES: Do you think it is possible to handle the evil in any other way than by gathering these people up, and isolating them, and treating them, of course.

Chief Constable CHISHOLM: That could be an experiment, but I seriously doubt whether such extreme legislation could ever be obtained.

Senator HODGES: You think it would be a good thing?

Chief Constable CHISHOLM: I think something could be accomplished, but I think it has to be attempted—to use the vernacular of the drug addicts—"when he runs off the dope". In other words, when he is in custody.

Senator HOWDEN: That is the only way of getting him "off the dope"?

The CHAIRMAN: Do you find any objection to drug addicts being placed in mental hospitals for care and treatment?

Chief Constable CHISHOLM: The instincts of most of them is they want to be at large. I will give it as my opinion that the percentage who have volunteered for treatment in mental hospitals is very small.

The CHAIRMAN: If he had a preference, do you think he would prefer to be in jail, rather than in a hospital?

Chief Constable CHISHOLM: I think that is just another case of "a rose by any other name would smell as sweet".

The CHAIRMAN: Does the Federal Government provide counsel?

Chief Constable CHISHOLM: Yes, because practically all of our arrests and prosecutions are made in conjunction with the Royal Mounted Police.

The CHAIRMAN: You attribute the work of the two forces together as keeping the drug addiction down?

Chief Constable CHISHOLM: I definitely do.

Senator HODGES: In your opinion, is a sentence of fourteen years a deterrent?

Chief Constable CHISHOLM: I think in a long-range programme, it will be.

Senator HODGES: I would like to ask you another question. Do you think drug addicts should be whipped? I happen to be on another Committee, and I am interested in that.

Chief Constable CHISHOLM: I do not think the addicts should be, but I think the pedlers should be.

Senator HODGES: I mean the trafficker or the pedler.

Chief Constable CHISHOLM: I think the pedler deserves to be whipped, because he is degrading his fellow men in a coarse way.

Senator HODGES: Chief Constable Chisholm, do you think that many pedlers are addicts?

Chief Constable CHISHOLM: I will say that, in the main, the pedlers are not addicts.

Senator HORNER: You think they should be whipped? They do not use the drug themselves, but traffic in it.

Chief Constable CHISHOLM: I will say that the occasional pedler drifts into being an addict. We have had a few cases like that.

The CHAIRMAN: Has any other honourable Senator a question to ask of Chief Constable Chisholm?

Senator HORNER: You have on record the jails in Ontario where they have been receiving those using drugs?

Chief Constable CHISHOLM: Not to my knowledge. I think that question could be better answered by some representative of the Department of Reform Institutions. I understand they may have some information on that.

The CHAIRMAN: Do you find drug addicts coming back again and again?

Chief Constable CHISHOLM: Very definitely.

Senator HODGES: Do you think most of the criminal addicts had criminal tendencies before they became addicted to drugs, or do you find they have become addicts as they became criminals?

Chief Constable CHISHOLM: The record does not necessarily prove that, because drug addicts might be convicted as being drug addicts, but have escaped detection on some other occasion.

I would say, however, that in many cases he would be a criminal first, and because of his associations in the underworld, would acquire the drug habit.

Senator GERSHAW: Do the juvenile offenders come from broken homes, or those with poor education? Is that the type?

Chief Constable CHISHOLM: The criminal addicts are usually those who come from poor surroundings.

The CHAIRMAN: Chief Constable Chisholm, we thank you most sincerely for your appearance here this morning. I do wish to thank you on behalf of the Committee.

Chief Constable CHISHOLM: Thank you, Mr. Chairman and Senators.
—Chief Constable Chisholm retired.

The CHAIRMAN: We were to have Doctor J. T. Phair, Deputy Minister, Department of Health, of the Province of Ontario, with us this morning, but unfortunately he is not able to be present.

We have instead, Doctor R. C. Montgomery, of the Department of Health, Province of Ontario, and I will ask him to come forward now, if he will.

Doctor R. C. MONTGOMERY (*Department of Health, Province of Ontario*):

The CHAIRMAN: Will you proceed, Doctor Montgomery, if you please.

Doctor MONTGOMERY: Mr. Chairman and honourable Senators, I have here a very short brief, which, with your permission, I will read.

STATISTICS REGARDING DRUG ADDICTION

The Ontario Department of Health, through its Mental Health Division, operates sixteen mental hospitals with a patient population of twenty thousand, and community psychiatric facilities including mental health clinics and consultant psychiatrists.

The mental hospitals are operated under The Mental Hospitals Act of Ontario. In the Act, a "mentally ill person" is defined as a person other than a mental defective who is suffering from such a disorder of the mind that he requires care, supervision and control for his own protection or welfare, or for the protection of others. Eighty per cent of patients are admitted by certification of two physicians.

Special provisions are in the Act for the admission of habitues (alcoholic or drug habitue). The following methods of admission are provided:

1. Voluntary admission (Section 46).
2. Deputy Minister's warrant (Section 47).—This requires a hearing before a judge in chambers of the County or District Court and a finding that the alleged habitue is so given over to the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs, or squanders or mismanages his property, or places his family in danger of distress, or transacts his business prejudicially to the interests of his family or his creditors, or that he uses drugs or intoxicating liquors to such an extent as to render him dangerous to himself or others, or incurs the danger of ruining his health and shortening his life thereby.

The reason that is quoted, is to indicate to the Committee, the criminal nature of the illness which usually brings a habitue before a Judge.

Under receipt of the report and evidence, the Deputy Minister may issue a warrant for a period of treatment not exceeding two years.

3. Certification by two physicians (Section 48) for a period not to exceed thirty days.

The physicians certify a person is a habitue, and then we have him for a period not to exceed thirty days.

The idea behind this section is that in matters of emergency, there may be a ready method of securing admission for the habitue, so under Section 47, a Deputy-Minister's warrant procedure may be gone ahead with during the period the person is in the hospital.

I think I should expand the information here a little. (*See Appendix S.*) It will be noted, first, that the numbers are very small as related to the total first admissions to all the Ontario hospitals for the various forms of mental illness, and mental retardation. Consequently, "drug addiction" here is used in a very broad sense, as the number of people suffering from addiction to morphine or heroin is very small, the greater number using barbiturates.

It is noted, in 1954, there were eleven patients in residence diagnosed as suffering from this condition, and three suffering from drug addiction without psychosis. Again, it will be noted the number was very small compared with the total in residence in the Ontario hospitals.

I may be reverting back to the first table, but the diagnosis represents the final diagnosis of the doctors in the hospitals. Some patients may come into the hospitals certified as being mentally ill, while others may come in under the habitue section. Every doctor remembers the section by which patients may be admitted to mental hospitals, and this is the final diagnostic category given in this table.

It will be noted that the figures regarding drug addiction are total numbers of patients in sixteen hospitals, so that none of the hospitals have a large experience in caring for drug addicts. In one of the larger hospitals, six patients (three men and three women) were treated as habitues during the year 1954. Of the three men, one was a barbiturate addict, one had been an alcoholic becoming a morphine and heroin addict, and the third had been alcoholic becoming a barbiturate addict. Of the three women, two had been alcoholic, going on to barbiturate addiction. The third woman was a morphine addict. The Superintendent has authority to discharge the patient when he considers he is sufficiently recovered.

Since I received notice to come to the Committee here, I have had a report from another large hospital, and the Superintendent advises that during the year 1954, not only drug addicts (morphine or heroin) were admitted, but during the year we did admit one man and twelve women who were certified as mentally ill, and who were diagnosed as psychosis Secondary, due to drugs (barbiturates, bromides, and so forth).

For the first three months of 1955, in straight-forward cases, the narcotic drug addicts have been admitted, although we have admitted three women diagnosed as psychosis Secondary to drugs (barbiturates).

In the field of community mental health during 1954, the mental health clinics dealt with 2 drug addicts. In the same year, the consultant psychiatrists dealt with 2 drug addicts. I may say that both of these mental health facilities in a community are composed of a psychiatrist, with a psychiatric social worker, a psychologist and clerical assistants. There are six psychiatric consultants in the communities across the province, and five mental health clinics.

The percentage of psychoses due to the use of drugs is relatively small in mental hospitals generally. On looking up the tables for the year 1953, of the ten psychiatrics due to drug addiction, two had been in hospital one or two years, one had been in hospital ten years or over, and two had been in hospital twenty years or more.

The CHAIRMAN: Was that for drug addiction, Doctor Montgomery?

Doctor MONTGOMERY: Yes, sir.

The CHAIRMAN: Heroin?

Doctor MONTGOMERY: Probably, although I have not the exact drugs as listed.

Senator HODGES: While we are on that section, would they be given any drugs while in the institutions?

Doctor MONTGOMERY: No, they would not.

The CHAIRMAN: Why the long term of ten years?

Doctor MONTGOMERY: It is just a question as to whether the basic condition may have been mental illness associated with drugs, and the mental illness continued on. The mental illness which is exhibited by patients in hospitals associated with drugs assume many forms, and is quite often related to the general experience with the deepest mental illnesses in the hospital.

Senator HODGES: They are primarily mental patients?

Doctor MONTGOMERY: Primarily, yes.

Senator STAMBAUGH: This is the first time we have had any evidence of any voluntary admissions to any institution. Just what does an addict have to do voluntarily to be admitted to one of these institutions?

Doctor MONTGOMERY: Possibly I should go on a bit. I have some information about that.

Senator STAMBAUGH: I thought you were finished. Will you proceed, please?

Doctor MONTGOMERY: I have a table here which shows all the various methods of admission to mental hospitals, for 1954.

In 1954, there were voluntary habitues admitted, ten men and one woman, a total of eleven. Again, we must remember that I am referring there to alcoholism or drug addiction. A large proportion are due to alcoholic addiction, the ratio being probably six or seven to one, due to alcoholism, rather than drugs, and we have here taken out the drug addictions to present before the Committee.

The CHAIRMAN: Do you find that many of those who go out as cured are re-admitted?

Doctor MONTGOMERY: Yes, there is quite an re-admission rate. Under the Habitue Act, or the certificates of two physicians, there were seventeen men and one woman—a total of eighteen—admitted in 1954.

Under the warrants by the Deputy Minister, there were three male admissions, and five female admissions, or a total of eight.

I am bringing that in just to indicate there are arrangements for habitues.

I might say, just to orient the admission record, that there were 3,126 admissions on two doctors' certificates, that is, they were certified by two doctors.

I think the general opinion of the Superintendents who are operating the mental hospitals is that the special section of the Act for habitues works satisfactorily in the mental hospitals. The Superintendents feel those people who are admitted under different classifications are properly cared for in the mental hospitals. Usually, there have been varieties of treatments tried out in the community before admission is requested under these three sections.

Very briefly, I just want to mention that there have been surveys regarding the situation with reference to the drugs as a factor in the production of mental diseases, and back in 1941, there was a paper written by Moore and Grey, in which they say:

The percentage of admissions due to the use of drugs is relatively small in the mental hospitals. It is .03 to 5 percent. of all admissions to United States mental hospitals. "Barbiturates and bromides are used mostly in the United States.

I mention that as a matter of interest. It is a figure which is getting old.

Another statement made at the same time reads:

The recovery rate for mental disease due to drugs is high, and the death rate is low. Prognosis, or outlook, for the mentally ill due to drugs, is more favourable than in other types of mental illness.

Briefly then, there are a relatively small number of drug addicts admitted to mental hospitals. The tendency is for them to recover from that initial mental illness, and go home. It is the feeling that provision for habitues in the mental hospital services is of definite value.

Mr. LIEFF: Of that relatively small number you mention, Doctor Montgomery, are any of them criminal addicts?

Doctor MONTGOMERY: No, they are not, sir.

Mr. LIEFF: None at all?

Doctor MONTGOMERY: I cannot remember any, in my considerable experience.

The CHAIRMAN: How many cures would you have—those who are actually cured?

Doctor MONTGOMERY: I hope I did not say "cured". They come to a point where they leave the hospital.

Senator HODGES: They are cured of their mental illness?

Doctor MONTGOMERY: Yes.

Senator HODGES: But not necessarily of their drug addiction.

Doctor MONTGOMERY: That is right.

Senator HORNER: My question has not been answered, Doctor. How does an addict obtain admission in a voluntary way? If he wants to obtain admission voluntarily, how does he go about it?

Doctor MONTGOMERY: Generally, he goes to his local doctor. He must apply to the Superintendent of the mental institution.

Senator HORNER: Is the Superintendent forced to admit him?

Doctor MONTGOMERY: No.

Senator HORNER: He may turn him down?

Doctor MONTGOMERY: Yes.

Senator HORNER: If he does admit him, how long does he stay?

Doctor MONTGOMERY: For a period not exceeding one year, but he can be discharged at any time.

Senator HORNER: If he wants to be discharged?

Doctor MONTGOMERY: On a voluntary admission, we feel it is not wise to keep him longer than he wants to stay, because the rehabilitation system gives him certain freedom around the hospital.

Senator HORNER: He can leave pretty well when he wishes?

Doctor MONTGOMERY: Yes. I think there is a notice required of some four or five days.

Senator TURGEON: Thinking, first of all, of those who reach the jails or prisons because of drug addiction; the same would apply to them in your institutions?

Is there any arrangement when an addict is leaving, that either a member of his family or a representative of some church to which he may belong, or the Salvation Army, or the John Howard Society, or an organization of that kind, is notified that the addict is leaving, and an attempt is made to have some welfare group get in touch with the addict, before he runs into a trafficker again?

Doctor MONTGOMERY: In one hospital, we have two full-time Padres, who come into the picture quite definitely. All hospitals have social service departments, and it is their province to make any arrangements they can to prevent the addict going back into the community.

Senator TURGEON: If he runs into somebody he knows, who deals in drugs, or is himself an addict—

Doctor MONTGOMERY: That is the province of the after-care department of the hospital, which tries to make the necessary arrangements.

Senator TURGEON: Does that relate to jails, too?

Doctor MONTGOMERY: I do not know.

Senator TURGEON: I am afraid it does not, but it does to the hospitals.

Doctor MONTGOMERY: Yes. There is a social service department in each hospital.

Mr. LIEFF: If you got 100 applications for voluntary admission, would you have facilities to handle them?

Doctor MONTGOMERY: No.

Senator HORNER: Have you ever thought what would be the cost throughout the country, regarding the great number of alcoholic addicts, and others? So far as I remember, when liquor was properly distilled, we never heard of such a thing. I am suspicious, they are getting bad drugs, and perhaps they are getting some in some of the liquor they are buying at the present time.

Doctor MONTGOMERY: What is the factor in regard to the addicts?

Senator HORNER: I feel suspicious sometimes they are getting drugs in some of the liquor. Would that not stand some investigation, in order to see that we have properly-distilled liquor?

Doctor MONTGOMERY: I have no knowledge of that at all.

The CHAIRMAN: Honourable Senators, are there any further questions to ask of Doctor Montgomery? (No response). If not, Doctor Montgomery, on behalf of the Committee, I wish to sincerely thank you for your appearance here this morning, and for the information you have given us.

Doctor MONTGOMERY: Thank you very much, Mr. Chairman and Honourable Senators. It was a pleasure.

—Doctor Montgomery retires.

The CHAIRMAN: Our next witness is Doctor F. H. Van Nostrand, Director of Neurology and Psychiatry, Department of Reform Institutions, Province of Ontario.

I will ask Doctor Van Nostrand if he would be kind enough to come forward at this time.

Doctor F. H. VAN NOSTRAND (*Director of Neurology and Psychiatry, Department of Reform Institutions, Ontario.*)

The CHAIRMAN: Doctor Van Nostrand, will you kindly proceed, in your own way?

Doctor VAN NOSTRAND: Mr. Chairman, and honourable Senators; I have not prepared a brief, and I do not think I have much to add to what you have already heard. I have three aspects on this matter, which I might bring to your attention, but if you prefer, I will wait for questions from the honourable Senators.

The CHAIRMAN: I think perhaps we would like you to discuss the three aspects you have in mind.

Doctor VAN NOSTRAND: The first is the legal supplying of drugs to addicts, which has been recommended in some quarters. I strongly endorse all of the arguments of Doctor Stevenson against the legal supplying, whether it is free or at nominal cost, and whether supplied in dispensaries, clinics, or by general practitioners.

Senator HODGES: You are against that?

Doctor VAN NOSTRAND: Yes. Doctors of my age, and older, in this part of Canada, remember with some bitterness when we were the "bartenders" and "bootleggers" of the province. It has been argued that the free supplying of drugs will take the profit out of the drug business. The legalized sale of liquor in Ontario did not put the bootleggers out of business. No one in this part of Ontario will argue that it reduced alcoholism. We know that alcoholism today, in this part of the province, is a greater problem than ever before.

Mr. Chairman, we do not know the various factors which govern the amount of addiction, whether it is drug addiction, or alcoholic addiction, or some other habits which injure individuals or society, but we do know there are at least four common factors.

First; the constitutional predisposition of the individual, whether you call it, as do the Lexington group, "the heavy weight of constitutional psychopaths of an inadequate type at the beginning, whether it is due to heredity or environment".

The second factor is the availability of drugs or alcohol.

Thirdly, the financial consideration, and, fourthly, the social acceptability.

Most of you will recall the graph which appeared in the Jose Committee report of 1948 and 1949, but I would remind you that graph showed a large number of convictions for drug convictions. Convictions for drugs in Canada in 1930 dropped to a deep low during the depth of the depression. It rose during the early part of the war, when there was more employment and more money, and I suggest that, in a way, it had to do with the financial ability of the people to purchase drugs, because we all know that at that time drugs were available on the black market.

After the second peak, the same graph shows a drop which coincides with the lack of availability; in other words, the declaration of war by the Americans and the shipping situation in the Atlantic and in the Pacific.

When it comes to the social acceptability, certainly alcoholism is a huge factor. When comparing London and Paris, we all know that Paris has the availability and cheapness of wine, but the final thing which makes Paris alcoholics out-number London or Toronto is that in Paris it is socially acceptable.

Moving to the second point; since drug addiction is not socially acceptable to a majority of us, even though alcoholism is acceptable in moderation in this part of Canada, it is my feeling that the law and sentences when used against the peddlers should be for the purpose of separating a man from society for as long a period as possible. I am not sure there is not that provision in the present law.

At the other end of the scale, I would agree with the recommendation of the Lexington group, as set out by Doctor Isbell last summer at a meeting of the Social Health group, that a short-term definite sentence, with a long-term indefinite sentence, is distinctly advantageous. It is doubtful if the present six months, one year or three years, is sufficient for reforming the addict. In some cases, he is more bitter, and more of a menace when he comes out of jail than when he first went in.

I think the reported success of the Lexington group, concerning an addict's short stay in isolation in hospital, is due to the fact that they still have strings on the former inmates, who are really on parole, and they have adequate, but rather an expensive follow-up. Therefore, without any changes in the present law, other than reducing the minimum which I think now is six months, I think we should press for much longer indeterminate sentences.

That brings up a question, and I cannot believe that there were a great number of cases which I have been forced to treat—just a small trickle of addicts—for twenty-five years, whether with marked success or not, requires, I think, a second-hand account.

Senator HODGES: How many have you treated in that time? Have you any idea?

Doctor VAN NOSTRAND: Not more than fifty or sixty, I should think.

Senator STAMBAUGH: You consider how many have been cured?

Doctor VAN NOSTRAND: Not more than five. Admitting that we know the Lexington group have had much greater success, I should say the reason cures are so few—particularly amongst the inmates of Reform Institutions—is because we have no control of them after they have served their terms. I know of only one case which may be termed as having been cured by incarceration. This man wandered into my office two months ago. He is fifty-eight years of age. I saw his file, and I saw he had been in Kingston and Burwash. His story—which I had no reason to doubt—was that after being in Kingston for three years, he was immediately placed in Burwash for two years, less one day, and at the end of that time, he never went back.

Senator WOODROW: On what do you base your cure, that is, on what length of time?

Doctor VAN NOSTRAND: Three years or longer.

Senator WOODROW: That is just for the time required for the cure?

Doctor VAN NOSTRAND: Three years or longer. Of course, my cases were more of professional people than the obviously "down-and-outer".

The CHAIRMAN: You are speaking of the mental cure, as well as the physical cure, when you say "three years".

Doctor VAN NOSTRAND: Yes.

Senator HOWDEN: Did that cure consist of isolation, generally?

Doctor VAN NOSTRAND: One was admitted to hospital on recommendation of the family's local doctor for one year less one day. Being a physician, he probably got more help.

Senator HOWDEN: Was that drug addiction or alcoholism?

Doctor VAN NOSTRAND: Drugs. As far as I know, he is off the drugs, but he is not yet out of the institution.

Mr. LIEFF: And, of course, a number of patients are treated at home?

Doctor VAN NOSTRAND: Yes.

The CHAIRMAN: We have found instances of a man being incarcerated for eight years for drugs, and the first day he is released, back he goes. He appears cured, and his physical well-being has improved, but mentally he has not been helped. That is why I asked you whether you cured mentally, as well as physically.

Doctor VAN NOSTRAND: We have one case in Burwash, who has been in the institution much more than he has been out for the past thirty-two years. He was in when I first checked his files. When he is admitted to an institution, he regains weight, and regains his vitamin efficiency, and he works hard. He is now sixty-one years of age, and he interests me, because he has been off drugs and on an adequate diet, and forced to work. As I say, he is on the wrong side of sixty.

These cases are not very great in number. As you probably are aware, the figures we have for the Ontario institutions are small. We have less than 60 known addicts in our institutions at the moment. However, that does not show the whole picture, because people from Ontario undergoing sentences and given long terms, are sent to Kingston. Of that small figure, six are serving sentences for breaches of the Narcotic Act and are not just the addicts.

Senator HODGES: Does that mean the peddlers?

Doctor VAN NOSTRAND: Our files generally show it is a case, perhaps, of somebody being with a group, and only having a few capsules. It is hard to say. I can check those six files, if it would be of interest to the Committee. In all our penal institutions, we have at least as many inmates serving sentences for crimes committed to support their addiction. Our check the first of this week shows we have more in for shoplifting and breaking and entering, than for breaches of the Narcotic Act.

Senator HOWDEN: In regard to the shoplifters; they are doing that, to provide themselves with drugs.

Doctor VAN NOSTRAND: Yes. Most of them have been at variance with society before they became addicts.

Senator HOWDEN: They do not have vicious criminal tendencies?

Doctor VAN NOSTRAND: Oh, no.

Senator HODGES: There are more delinquent tendencies?

Doctor VAN NOSTRAND: Yes. Perhaps some youngsters stealing cars, and things of that kind.

The CHAIRMAN: Do you find many of them were alcoholics before they began their addiction?

Doctor VAN NOSTRAND: I co-related that with the Lexington group, because they give an estimate of between forty and sixty per cent of their drug addicts have been alcoholics. I think Doctor Stevenson gave his figure as a little lower. I think ours is about forty per cent or fifty per cent.

We have few juvenile addicts. We have some in the age group of 23 or 24, but they admitted drug addiction since they were 17.

When you consider the size of this province, I agree with the evidence given by Chief Constable Chisholm and Commissioner McClellan. We have no great problem in drug addiction. We have, in alcoholism.

The CHAIRMAN: That is very interesting. Have honourable Senators any further questions to ask of Doctor Van Nostrand? (No response). If not Doctor Van Nostrand, on behalf of the Committee, I wish to thank you sincerely for coming before us this morning, and giving us the information you have. We appreciate it very much.

—Doctor Van Nostrand retired.

The CHAIRMAN: We have with us this morning, Doctor J. R. Mutchmor, Secretary of the Board of Evangelism and Social Service, of the United Church of Canada.

Doctor Mutchmor, I would ask you to come forward, and the Committee would be glad to hear you.

Doctor J. R. MUTCHMOR (*Secretary, Board of Evangelism and Social Service, the United Church of Canada*).

The CHAIRMAN: Will you proceed, Doctor Mutchmor, please.

Doctor MUTCHMOR: Mr. Chairman, and honourable Senators. We are very grateful for this opportunity to appear and present a brief.

I have with me, Reverend Wesley Hunnisett of the Fred Victor Mission. We had hoped to have Reverend M. D. Smith, who works in the Toronto area, but he had to leave, and we have helping us, Reverend H. McF. Morrow, from the First Church of Vancouver, who has recently come to Toronto.

Honourable Chairman Thomas Reid and Honourable Senators, members of the Special Committee of The Senate of Canada appointed to study and report on The Traffic in Narcotic Drugs.

Honourable Sirs:

1. Introduction:

This brief is presented on behalf of The United Church of Canada by its Board of Evangelism and Social Service. Instruction to this Board to study the problem of narcotic drug addiction and the care and treatment of drug addicts was given by the Fifteenth General Council of the United Church at its meeting in Hamilton, September 1952. The Council's purpose in issuing this instruction was, to quote its resolution, "to ascertain some practical measures in the carrying out of which our Church may share in order that progress be made toward the prevention of drug addiction and means of cure be made available to those who are now its victims."

In the short time available to assemble materials for this brief, help has been received from the Board's Vancouver office, from the Rev. H. McF. Morrow who has served for several years in downtown Vancouver and is now the Executive Director of the University Settlement in Toronto; Rev. Dr. Wesley Hunnisett, Superintendent of the Fred Victor Mission, Queen and Jarvis Streets, Toronto, and other United Church workers in city areas where the problem of drug addiction is acute.

Those who present this brief are well aware of its inadequacy. It is believed however, that, without claiming any special technical skill in ascertaining the nature and extent of the problem and its solution, the Board of the United Church responsible for this brief can be helpful at *three points*. The brief therefore includes brief comments concerning:

FIRST, the need and place of religion and of spiritual work and power in dealing with drug addiction including its prevention and cure:

SECOND, the place and function of the Christian Churches to be the conscience of the community and nation in order that the public be alerted and informed concerning all major moral issues and in this instance of the grave aspects of drug addiction in order that public opinion in support of decent behaviour and healthy wholesome living be developed; (In the discharge of this function it should be the aim of the Christian Churches to avoid emotionalism. The need is the development of an intelligent concern and a public support for a constructive program for the reduction of Drug Trafficking and the general problem of drug addiction.)

THIRD, the importance of maintaining and developing a high and serious sense of responsibility by persons in elected and appointive administrative posts whose duty it is to enforce laws, prevent crime, improve deteriorating city districts and generally lift the level of a community's life and especially its downtown life, to a more wholesome and healthy state.

I

THE GRAVITY OF THE PROBLEM

At the risk of repeating information already made available to the Senate Committee, those who present this brief would point out that the drug traffic today is an international one. For example, United Nations reports reveal that one drug, opium, is overproduced. The annual world requirement of opium is 450 tons; the annual production exceeds 2,000 tons.

It also is generally known that factories in Italy, Japan and Turkey produce large quantities of heroin. Sixty percent of drug addicts in the U.S.A. use heroin.

Unfortunately, international control of drug shipments improves slowly. Meanwhile, shipping facilities increase. The drug traffic between parts of Asia Minor and Italy on the one side and North America on the other is very heavy.

The effects of this traffic in Canada, well known to the R.C.M.P. and other enforcement officers, for many years are now more widely known in our country. The gravity of the problem for our land is indicated by statements from the Federal Department of National Health and Welfare to the effect that the number of known Canadian addicts totals 3,212 persons of whom 515 are medical addicts; 333 addicts in the professions; and 2,364 criminal addicts. It is noted that about two-thirds of the known addicts are in British Columbia.

Mr. K. C. Hossick, Chief of the Division of Narcotic Control, Ottawa, in an address to the United Church, Board of Evangelism and Social Service, February 1954, described Drug Pedlars as follows:

You have seen much of these things, and we were pleased to have Rev. Mr. Hossick at that meeting, and we have been very closely in touch with the Department since that time.

The number of addicts who require daily sustenance through narcotic drugs must find a source of supply through underworld sources and, consequently, there is associated with this problem those who are known as traffickers or peddlers who are engaged in the illicit distribution of drugs to addicted people. The word "trafficker" or "peddler" includes not only the vice czar who is responsible for importing the drugs into Canada by illicit means but his various henchmen who are responsible for the wide ramifications of distribution down to the street corner. All of these persons are traffickers and as such constitute the great evil which the enforcement authorities are seeking to eliminate. Traffickers are not in the business for humanitarian reasons but only for profit and the profit incentive is great. For example, an ounce of Heroin that would sell for \$12.00 in the legitimate market would have an illicit value at the point of distribution of from \$5,000 to \$8,000. This is difficult to credit, and it is only by an understanding of the practices of the traffickers and the hopeless needs of the addicts that this can be understood. To explain, one ounce contains 437½ grains and a dose or shot as it is called is usually a fraction of a grain which is usually diluted with other substances to stretch the trafficker's supply. A dose commands three to five dollars on the street corner from the peddler and thus the original ounce may realize such a fantastic sum as I have mentioned.

Our First Recommendation. is that there be an even more intensive and long continued study of the problem to supplement the carefully gathered data of the Division of Narcotic Control and such studies as have been conducted recently by the Vancouver Community Chests' Committee, and the Committee on Drug Addiction of the Welfare Council of Toronto. We believe that more information is required. There is a special need of thorough study of the life

history of some selected addicts. Studies such as those conducted by the Glueck's of Harvard University and Sir Cyril Burt of England in Delinquency and Crime are much needed to reveal inner and hidden aspects of the Drug Addiction problem.

In connection with this recommendation to study, we note with commendation the research work sponsored by the Federal Department of National Health and Welfare, now in progress in Vancouver under the direction of Dr. George Stevenson. We believe that there is urgent need for such pilot investigations. We support the spending of public funds for purposes of this kind. The drug addiction problem must be probed and studied *at depth* by able men such as Dr. Stevenson. Such difficult tasks require the work of the most able persons available. It will only be a waste of time and money if inexperienced personnel are employed.

II

THE PLACE OF RELIGION IN PREVENTION AND CURE OF DRUG ADDICTION

It is the basic and fundamental argument of this brief that drug addiction which in many ways is not unlike but even more serious than alcoholism, is the result of human weakness. Drug addiction is a moral problem with medical, legal, community and other aspects. In the last analysis the drug addict when well advanced in the illness of his soul and body is beyond help at the human level. The confirmed drug addict needs the help of the doctor, the social worker, the probation officer, the employer, the labour union and many others. Above all else he needs the help of God. To much too large a degree the Christian Church has failed to do all in its power to save the drug addict.

The Second Recommendation, therefore of this brief is to urge this committee to consider favorably including in its report a finding in support of the selection and appointment of trained consecrated men and women of God to work both in down town urban areas of such large centres as Vancouver, Montreal and Toronto; (1) *to rescue* those who are beginning as drug addicts; (2) *to help locate* the habitual and confirmed addicts and to help them to move to treatment centres; and (3) *to labour to make* the Grace of Jesus Christ an effectual means of rehabilitation in treatment centres established for the cure of drug addicts in Canada.

It is the argument of this brief that such religious workers, Roman Catholic and non-Roman Catholic be chosen entirely on the basis of proven capacity. Such workers might very well be appointed on a term basis. A period of five to ten years is suggested.

It should be pointed out that the religious worker must be prepared to share his life and his experience of the redemptive power of God with the addict. The consecrated worker must offer himself. He must be so close to the addict to be helped as to involve his own life with that of the victim to be saved. To ask for this kind of religious service is to require a kind of sacrifice rarely called for but anything less will be of no avail to most drug addicts.

III

THE CONSCIENCE OF THE STATE

The United Church of Canada believes that the Christian Church should be the conscience of the State. With this principle in mind the United Church will continue to undertake to inform itself concerning the gravity of the Drug Addiction problem. Our ministers and members who have received some information and counsel on this question will become better informed. We will give more support to our ministers and social workers who particularly in some downtown city churches, hostels and community centres, see frequently the evil effects of the Drug traffic.

In this general connection we have learned of an experiment in Church work in Vancouver on behalf of drug addicts. In this particular piece of work the clergyman concerned is trying to follow some of the principles and program of Alcoholics Anonymous.

SENATOR HODGES: Are you working with Alcoholics Anonymous?

DOCTOR MUTCHMOR: I believe they have a small beginning along that line. This is amongst the Christian churches in Vancouver.

There may be a fruitful lead here. The United Church will seek to learn from such experiments. We will note the role which a church member who is willing to be a friend of an addict may play. We believe that this "person to person" technique is a significant one.

Our Third Recommendation is that this Committee of the Senate consider favorably, including in the findings of their report a section on the duty of the Christian Church to be the conscience of the State. We believe that such a section should be specific and extensive.

The Christian Church should be urged and enabled to become a much closer ally of the State on the drug addiction sector of the Moral Issues front. To this end it is suggested that the governmental authorities concerned organize and hold conferences at which Church leaders and workers be informed about the nature and incidence of drug addiction. That was, without question, the thing which Mr. Hossick would be most interested in. He brought a film, which was only showed to the police, but we were permitted to see it, and we spent a whole morning on this discussion, and we felt that kind of thing could be carried out elsewhere with good results.

At such conferences the need for preventive work would be stressed. In general an effort would be made to mobilize the resources and personnel of the Christian Churches in order that by a combined operation of persons of ability and goodwill a successful effort be made to build healthier community life.

In this same connection the Christian Churches should be given an opportunity to join in a more effective program of combatting evil. It is the argument of this brief that drug trafficking can be most effectively reduced by co-ordinating the work and efforts of all agencies determined to cleanse and purify the life of threatened communities and those who live in them. Without going into more detail it will suffice to point out that such social ills as drug trafficking can be reduced by constructive as well as antagonistic methods. While supporting all forms of law enforcement we believe there is also much value in positive endeavours such as slum clearance, better housing, more healthy recreation and related endeavours.

It is to be noted also that the Churches and the State can make their common efforts in combating evil more effective if and when a more coordinated program of public education is devised. We would urge that a National program for the education of adult groups and also youth organizations on the dangers of drug addiction be instituted by the department of National Health and Welfare. Good results are being achieved by some provincial bodies in programs of education for the general public concerning alcoholism. Similar work should be done about drug addiction.

IV

RESPONSIBILITY IN CRIME PREVENTION AND LAW ENFORCEMENT

Out of a long and varied experience in city work, the United Church is keenly aware of the need for the best and most responsible kind of civic government and administration. Such honest and efficient work is urgently required in the larger cities as well as other places in Canada.

Long ago Lord Bryce in his two volume work on "The American Commonwealth" pointed out that the United States would be challenged by corruption and crime in its large cities.

More recently the reports of the investigations of the American Senate Committee on Organized Crime under the chairmanship of Senator Estes Kefauver reveal that crime in the United States is highly organized. Further these reports show a close relationship between the growth of crime and the corruption of civic governments. Moreover the corruption of the administrations in the City Halls of several large American urban areas was shown to have a direct and evil effect upon the forces of law enforcement concerned.

It is the argument of this brief that there are patterns of crime and "families" of criminals. Crime is a self breeding and propagating activity. There is always in every large city a close relationship between such evils as: liquor and drunkenness, highly commercialized race meets and legalized and illegal gambling, organized sexual vice and drug addiction.

Associated with the growth of these evils is the desire for profits. The urge to get and accumulate financial gains from evil endeavours is a powerful one. All too often those who yield to this urge and become vice czars, work themselves into positions where they can and do corrupt city officials and police forces.

It is the considered opinion of the United Church of Canada that excellent work is being done by the R.C.M.P.—the Narcotics Division, Ottawa, many chiefs of police and other law enforcement officers.

It is also our opinion that these law enforcement officers must have the largest possible measure of high level administrative support.

We believe that the British tradition that the Attorney General of a province is the chief law officer of the Crown, must be strictly and loyally observed. Further we believe that every mayor of every large city should take his position as a chief magistrate most seriously.

We believe that, if and when, every large city in which a drug trafficking and drug addiction problem exists, gets one hundred per cent honest law enforcement support from its mayor and chief magistrate as chairman and head of its local police commission, that the work of the Narcotics Branch and the R.C.M.P. will be made far more effective.

It is with these views and convictions in mind that the United Church has viewed with alarm, reports about a Room 1735 in Toronto and a formerly low level of law enforcement in Montreal. We are pleased to learn that there is now stricter law enforcement in Montreal.

It is therefore a *Recommendation* of The United Church of Canada, that all provincial Attorneys General and all Mayors, particularly of large cities, be urged to discharge their well-defined duties in the most efficient and honest manner. We urge further that all councils of larger cities be particularly diligent concerning law enforcement. We believe that given support by the elected representatives of the people on municipal and provincial bodies, that the police forces of Canada will continue to render a good account of themselves. Thus all criminal activities, including Drug Trafficking, will be reduced.

Now, Mr. Chairman, I have tried to summarize these recommendations for what they are worth, as follows:

SUMMARY

The Recommendations briefly stated are:

First, Governmental and public support of present and future research work *at depth* with the particular objective of learning the character and behaviour pattern of the drug addict, including the reasons that lead to a person's beginning the habit and the factors that would govern the addict's response to efforts at treatment and cure;

Second, The appointment of spiritually minded and equipped religious counsellors to help drug addicts in preventative and early rescue efforts and also in the treatment and cure of the confirmed and often stubborn and obstinate addict. In this kind of work the United Church would favor compulsory and long treatment of confirmed cases;

Third, The coordination of the policies and programs of prevention, law enforcement, treatment and cure, concerning all aspects of the Drug Problem, of the State and the Christian Churches. To this end it is recommended that a National Program of Education concerning the problem be undertaken. Conferences for Church and Social workers arranged by governmental departments concerned, are recommended.

Fourth, The acceptance by Provincial Attorneys General and Mayors of large cities of their duties as chief law officers of the Crown and Chief Magistrates, respectively, in support of all law enforcement officers at work against Drug Trafficking is strongly recommended.

Signed—

BOARD OF EVANGELISM AND SOCIAL SERVICE
THE UNITED CHURCH OF CANADA

Rev. Angus MacQueen,
London, Ontario,

Chairman.

Rev. J. R. Mutchmor,
Toronto, Ontario,

Secretary.

Others Present:

Rev. Wesley Hunnisett,
Fred Victor Mission, Toronto

Rev. H. McF. Morrow,
First United Church, Vancouver,
(recently transferred to Toronto)

Rev. M. P. Smith,
United Church minister in attendance
at Toronto Courts and the Don Jail.

The CHAIRMAN: Have honourable Senators any questions they would like to ask Doctor Mutchmor?

Senator HORNER: What we heard in Vancouver on that, was rather startling. Several young people who appeared before our Committee, as addicts, claimed there was no one to meet them after their time in jail, and when they left the jail, the first persons they usually met were their former comrades and addicts. They claimed there was no representative of any church, or no welfare officers met them when released.

We had one girl who had served two years, who went from Vancouver to Kingston Penitentiary, and was released from there, and came to Toronto, and was only in Toronto about an hour when she got what they call a "fix". Her story was there was no one to meet her, and if there had been somebody, from a church or some welfare organization, who had met her, as she had a good home, the possibility is she would have returned home.

It occurred to me that surely the churches and other welfare organizations, could get permission to secure information from the jails as to when these young people—and I mention the young people particularly—are to be discharged, and then some proper type of person could meet them, and, if possible, provide work for them, but, as I say, they came before the Committee, and said they were simply thrown back amongst their former companions again.

Senator HODGES: Doctor Mutchmor, I would like to ask you a question. I notice on page 3 of your brief, you refer to the "National problem", and you say:

The gravity of the problem for our land is indicated by statements from the Federal Department of National Health and Welfare. — — and so forth.

We have been given to understand by various witnesses, through the medium of questions, that curiosity is one of the factors which starts a good many people on drug addiction. Do you not think that some programme of nationally-organized education might help that?

Doctor MUTCHMOR: I think it is agreed that a little knowledge is a dangerous thing, and a certain amount of knowledge of the wrong kind can be distributed through cheap magazines, and, to some extent, through T.V., and other media, and also through certain press stories.

We think the National Department of Welfare has made a beginning in certain types of education. Very much good work is being done in connection with alcoholism, and we think if the Department concerned would do it—with the advice of educationalists, then the right kind of information would go to the public.

I did not catch the name of the previous speaker—

The CHAIRMAN: Doctor Van Nostrand.

Doctor MUTCHMOR: But he spoke about "social acceptability". We do not think that a "taboo" should be kept on drug addiction, but if we do not watch out, the people who are connected with it, can make it appear so that even the most evil matters are made to appear reasonably good.

That is the way we see it.

The CHAIRMAN: Have honourable Senators any further questions to ask Doctor Mutchmor? (No response). If not, Doctor Mutchmor, on behalf of the Committee, may I say we greatly appreciate your coming before us, and we were very glad to hear from you.

—Doctor Mutchmor retired.

The CHAIRMAN: Our next witness is Mr. R. S. Beames, representing the John Howard Society.

Mr. LIEFF: Mr. Chairman and Senators, I am advised that with Mr. Beames is Mr. A. M. Kirkpatrick, the Executive Director of the John Howard Society, who will be pleased to endeavour to answer any questions which the Committee may care to ask.

The CHAIRMAN: Mr. Beames, I will ask you to come forward. We should be very glad to hear from you.

Mr. R. S. BEAMES (*The John Howard Society*).

The CHAIRMAN: Will you proceed, Mr. Beames?

Mr. BEAMES: Mr. Chairman and honourable members of the Committee; I will read this short brief, with your permission and then if there are any questions, Mr. Kirkpatrick, Mr. Gaw or Mr. Hawes, may be able to help me try and answer them.

The Members of the Senate Committee
on Narcotic Drug Addiction.

Honourable Senators:

In the course of our work as an after-care agency assisting men and women discharged from penal institutions we have served a number of persons who had been addicted to narcotic drugs prior to their imprisonment.

Most of these ex-inmates had been sentenced to a prison term as a result of addiction though some had been convicted of other offences. It is difficult to state the total number of such addicts to whom we have extended our service, but a conservative estimate would place the figure at not less than one hundred and twenty-five during the past six years. A careful check would probably increase this number.

We have worked intensively with a great many of these people and have extensive files concerning our professional relationship with them. In almost every case there was quite a history of addiction going back over several years. In one case the person had first become addicted in 1915 though the first conviction for addiction did not actually occur until 1922.

In a number of instances we were able to be of significant help in aiding the man or woman to stay free of addiction for a substantial period of time. A few of these people have been able to continue to live without drugs up until the present day.

Our purpose in coming here is to provide some information about this latter group in which there are at least seventeen former addicts, known to us, who have been free of drugs for a considerable period of time. Most of this group have been able to lead useful, productive lives. All of this group have been free in society for at least one year and fourteen have been out of prison for over two years. We have heard of a number of other cases of former addicts who have also remained free of drugs, but such cases are not well known to us and therefore we are not including them among the seventeen mentioned above.

Included among these seventeen cases are ten men and seven women. Their ages range from approximately thirty to sixty, with most of them being in their mid-forties. All have had more than one criminal conviction registered against them and all have been convicted at least once for possession of narcotics. A number of them have extensive criminal records including convictions for a wide range of offences.

While we know that we were able to be of considerable assistance in helping some of these people get re-established and in fact discussed freely with them their former addiction, there were undoubtedly other factors operating that added to their strength in carrying on their lives without narcotics. Though we were active with some of the others, our contacts were not as intensive and our assistance in helping them with their problem was probably a much less important factor.

The outstanding fact, however, is that these seventeen persons have not returned to drugs. This would seem to counter-balance the contention of many that the prospect of an addict staying away from drugs is almost hopeless. On the contrary, our experience seems to indicate that, if adequate provision were made for treatment and after-care of convicted addicts, a good percentage could be helped.

We stress after-care because we feel that this is fundamental to a proper treatment programme. The greatest problems besetting an addict are faced after his release from prison or hospital when he returns to the community. Here he must again find a place for himself. We recognize that addicts are weak, damaged people who have lived extremely abnormal lives in the community, often isolated from their relatives, friends and neighbours, frequently associating in large part only with other addicts, and using narcotics as a crutch to enable them to carry on a compensated existence.

Referring again to the seventeen cases known to us, we said that we do not know the precise reason for their ability to abstain from drugs but there is no doubt that they have been able to live lives significantly different from those they lived before.

In most cases they moved entirely away from their old associates nor did they any longer frequent those areas of the city where drugs are most easily

obtainable. In some cases they even moved to suburban areas or to small communities away from Toronto. For the most part they were able to obtain jobs suitable to them from which they derived some satisfactions. Most of them, in addition, found satisfactions and obtained strengths from finding new associations in the community or re-building old relationships. Two women, for instance, re-united with their husbands. Two others formed close ties with local churches. In other cases families extended the hand of friendship.

The basic factor, however, is that these people wanted to quit drugs. It is only after they quit and took steps to make something of their lives that these other circumstances began to work out. e.g. re-union with husbands and families, acceptance into groups and churches, acceptance by employers.

Most of these people made the initial decision in prison. Some wavered and fell back on drugs at least once after release. We know that at least three of these people had further passing experiences with drugs, but they were able to pull back in time. Having made this decision they needed and were able to find something in the community that could strengthen and further this resolve. Some were strengthened by our Society, others through different relationships. In a few cases it was only the initial determined resolve that carried them through.

It should be mentioned that not all these seventeen made this resolve for positive reasons. Two at least, and possibly three, made this initial decision for fear of being charged as habitual offenders if again convicted. Nevertheless, positive reasons in large part replaced the original negatives as these people found places for themselves in society and realized they could lead satisfactory lives without drugs.

The man who uses or has used drugs must operate under very heavy handicaps. The public generally are very fearful of these people. Employment agencies rate them at the bottom of the employability scale whether they have skills or not. They find little acceptance among the general prison population and both fellow prisoners and prison officials regard their plight as hopeless. All this, coupled with their own feelings of helplessness, makes their recovery almost impossible.

In spite of all that has been said about the problem and treatment of drug addicts we suggest that, if seventeen people known to us can make a recovery, then with help from properly organized facilities such as clinics, hospitals, and treatment facilities in prisons, all related to after-care agencies in the community, many more such people can be assisted to find a new way of life.

There is too little known and too little being done about this problem; but our experience would indicate that there is urgent need to initiate treatment programs in which careful research and study can be made of the many factors involved. This sickness has tremendous significance not only in the wasted and tortured lives of the addicts, but in the social and economic consequences for society.

R. S. BEAMES,
Casework Supervisor,
John Howard Society of Ontario.

The CHAIRMAN: Honourable Senators, are there any questions you would like to ask the representative of the John Howard Society?

Senator TURGEON: Regarding the meeting of the addicts, upon discharge, or, in fact, any prisoners from our institutions: does your Society find out what persons are in the jails in certain areas, and when their sentences will have expired, and when they will leave, and then do you try to arrange to meet them?

Mr. BEAMES: The majority of addicts with which we deal are released from Federal penitentiaries, particularly at Kingston, Ontario. We have a John Howard representative in Kingston, who does the pre-release work for us. Before any man is released, he is contacted by a probation officer, and if he wishes to see us, we are advised, and he is seen a substantial period prior to his release, and his problems will be discussed, and he will be advised, or at least he will be referred to our office in Toronto, or to one of our offices in one of the other communities in the province, and we notify that office, so they will be prepared, when he reports to them.

Senator TURGEON: You know when they will be discharged?

Mr. BEAMES: Yes.

Senator HORNER: Have you a man at Kingston?

Mr. BEAMES: Yes, he is delegated there, and practically his entire work is to contact these men who are released. We do not see them all. We only see those who ask for our assistance. There is another category which does not ask for it. However, if they come to our office after their release, if we do not have all the information we require, we scurry around and try to get all the information required. But in a majority of cases, we have considerable amount of detailed information about these men who come to our office.

Senator HORNER: Have you any women coming to you?

Mr. BEAMES: No, that job is now being done by the Elizabeth Fry Society in Toronto, Kingston, and Ottawa.

Senator STAMBAUGH: You will help every prisoner in these institutions, if they so wish?

Mr. BEAMES: Yes.

The CHAIRMAN: Do these inmates just go back to their old quarters?

Mr. BEAMES: There are other facilities available in the cities. They can approach the Salvation Army, there is the Church Army, and they can seek assistance from the Department of Reform Institutions, of which Doctor Van Nostrand is the senior man, and they can seek assistance from the parole and rehabilitation department.

The CHAIRMAN: Speaking generally, do you find the relatives and parents reluctant to have much to do with them after they have been convicted of drug addiction?

Mr. BEAMES: Many of the people with whom we deal have not gone just through one institution, but have gone through a series of institutions in the last fourteen or fifteen years. They are mostly people who have lived a life of crime, and have been addicts for many years.

Their relationships have been completely shattered years ago. They have nothing in the community.

Senator STAMBAUGH: Their relationship is entirely with the penitentiaries and other penal institutions?

Mr. BEAMES: No, that is not quite true. I would say that slightly more than 50 percent of our work is with Federal penitentiary cases, but we also have a great many reform institution cases, mostly in Ontario, plus certain people from local jails in Ontario.

Senator STAMBAUGH: You mean the city jails?

Mr. BEAMES: Those are referred cases. We do not open our doors to all people released from places like the Don Jail in the city of Toronto. If we did, we would be quite swamped.

But it is the referred cases from the provincial reformatories whom we normally handle in Toronto, as well as in other areas in Ontario, and that is

why we handle more reformatory cases than penitentiary cases. It is because there is such a concentration of men in the City of Toronto.

The CHAIRMAN: To me, you have a splendid record. You would guarantee 17 cures?

Mr. BEAMES: Mr. Kirkpatrick says, "Do not say they are cured". We do not say they are cured. We say they are not using drugs.

I will say that some of these people have become established in a community, in a local way. We know of one man who is partly an alcoholic, although he can do some work. His addiction goes back from 1922, to his last release in 1951 or 1952, in January. This man was so seriously damaged that he cannot lead a fairly productive life, and he must have the crutch of alcohol to enable him to carry on, but he does not use drugs. He works mostly in the Niagara fruit belt.

We know of women who are alcoholics and prostitutes, but they do not use drugs. The one feature is that all the people associated with this business who know one very well, and have formed their opinions independently, and know that she is not using drugs.

Most of the others are steadily employed and leading productive, useful lives.

Senator LEGER: What success have you had with the young addicts?

Mr. BEAMES: It is my belief you have more success with the older addicts. The point I made in my paper is that a number quit voluntarily. It is a difficult decision to make. Many of them go through a great deal of soul searching, and most of them make the decision for themselves. This may be due to maceration, upon becoming adults. It may also be due to their less ability to support the habit, which is a very expensive one. Or it may be due to the fact that they are "fed up" with this business, and are prepared to listen to counselling on this subject. Finally, a number of them are afraid of the Habitual Offenders Act.

Senator HORNER: After they become saturated with it, it does not do them very much good?

Mr. BEAMES: They have to go a year or two without it to get back where they really can enjoy it again.

The CHAIRMAN: Have honourable Senators any further questions to ask of Mr. Beames? (No response). If not, may I say, Mr. Beames, on behalf of the Committee, that we thank you sincerely for coming here this morning, and for the information you have given us.

Mr. Beames retired.

The CHAIRMAN: I think we will probably have time for one more, before the luncheon at the Royal York Hotel. I will ask Mr. J. G. Hall, representing the Welfare Council of Toronto, if he will kindly come forward.

Mr. J. G. HALL (Representing the Welfare Council of Toronto).

The CHAIRMAN: Will you proceed, please, Mr. Hall?

Mr. LIEFF: Mr. Chairman, before Mr. Hall proceeds, may I say that Dr. J. K. W. Ferguson, is with Mr. Hall this morning.

The CHAIRMAN: Will you proceed?

Mr. HALL: I have a very short brief, Mr. Chairman and honourable Senators, which, with your permission, I will read.

The Toronto Welfare Council interest in drug addiction was stimulated by the publication, in 1952, of the Ranta Report on Drug Addiction. Its recommendations were studied by a Committee made up of representatives from the following areas: medicine, including public health, psychiatry, and pharmacol-

ogy; law, law enforcement and prison reform; religion; social work; and alcoholic research, most of whom have had some direct association with drug addicts.

There was some divergence of opinion amongst the members of the Committee on various aspects of the problem of drug addiction. There was agreement, however, as to what action we believe should be taken by the Federal Government specifically in the field of research. Because of this agreement, we have taken this opportunity to present the opinions of our Committee.

Our study of drug addiction and what should be done about it exposed how little is actually known about the following topics on which research is needed:

1. The factors which contribute towards creating drug addiction.
2. The types of patient who might benefit by treatment.
3. The place of compulsion in treatment.
4. The effects of different treatment methods.

5. The part that educational programs may play as a deterrent to potential drug addicts.

Emphasis in the past has centered on the legal control of drugs. Little attention has been devoted to the medical and treatment aspects of the problem and the importance of developing facilities for full physical, psychiatric, psychological and social assessment, hospital treatment (where indicated) comprehensive rehabilitation, and long-term follow-up and after-care services.

We believe that the time has come for the Federal Government to give some leadership in stimulating, co-ordinating, and supporting research across Canada towards gathering basic information about drug addiction which will serve as a guide to future action. Programs of treatment and research established in the various provinces would be greatly benefited by an organization at the federal level to co-ordinate and support their efforts.

We believe that only through the development of such research can we hope to find methods to overcome the discouraging lack of success in respect to treatment procedures.

The figures for drug addiction in Toronto may not appear massive. However, the personal problem looms very large and the effect on crime and other costs presents a problem which is too serious to ignore.

Recommendation

The Toronto Welfare Council would, therefore, present the following recommendation:

THAT a National Advisory Committee on Drug Addiction to the Department of Health and Welfare be established for the purpose of stimulating, co-ordinating, and supporting research on drug addiction across Canada.

The CHAIRMAN: Honourable Senators, are there any questions you would like to ask Doctor Hall? (No response). If not, we appreciate very much your coming down, Doctor Hall, and for presenting the information you have, and on behalf of the Committee, I wish to thank you.

Mr. J. G. Hall retired.

The CHAIRMAN: We will adjourn now until two o'clock this afternoon.

The Committee adjourned at 12:10 p.m., to reconvene at 2 p.m.

AFTERNOON SESSION

Toronto, Ontario,
Friday, May 20, 1955.
2:00 p.m.

The CHAIRMAN: Honourable Senators, we are ready to proceed with this afternoon's agenda. Our first witness is Mr. Norman Mathews, Q.C., former Special Prosecutor for the Department of Health and Welfare.

Mr. LIEFF: May I add for the record that Mr. Mathews is a very modest man. I could not get too much out of him concerning his career, but he has been Senior Counsel in Ontario for a number of years, and has prosecuted some 500 narcotic drug cases.

The CHAIRMAN: We are very glad to have him here.

Mr. MATHEWS: Thank you very much, Mr. Chairman and honourable Senators.

Mr. NORMAN MATHEWS, Q.C. (Former Special Prosecutor under the Opium and Narcotic Drugs Act).

Senator HODGES: I understand you have prosecuted 500 cases, but you only had 400 addicts?

Mr. MATHEWS: Actually the number we prosecuted were those who came from Vancouver, until we scared them back there. Most of them now are in Kingston.

Senator HODGES: They formerly said "wise men came from the East", but, apparently, they came from the West.

Mr. MATHEWS: I think the only wise drug addicts are those who have stopped.

The CHAIRMAN: Will you proceed, please, Mr. Mathews?

Mr. MATHEWS: Do you want me to give you some of my views, or will you ask some questions first?

The CHAIRMAN: Tell us what you have in your mind, and we will ask questions later.

Mr. MATHEWS: There are a few suggestions I would like to make. There is one thing which has impressed me as being an unfair part of the Opium and Narcotic Drugs Act, involving the question of physicians.

As you probably know, where a doctor is charged with peddling drugs—and I have had the experience of prosecuting several of them—I have found, especially in the smaller centres, it is almost impossible to convict a doctor with a jury.

In the first place, the practice of the Department is to proceed by indictment in practically all drug cases, and when you are proceeding by indictment against a doctor, it is alright in the large centres, like Toronto where you have a jury, but if, as I have had to do, you prosecute a doctor before a jury in a smaller centre, no matter how overwhelming the evidence is, it is practically impossible to secure a conviction. I have had cases in which the case built up against a doctor for selling drugs has been overwhelming, where he has made a terrific profit from it. In one case in particular, the judge in reply to some objection to his charge made by defence counsel, remarked that it was the strongest case he had ever heard against an accused person in all his time on the Bench, but, in spite of that, the jury acquitted him. One of the jurymen met me in the corridor after the trial, and told me they had decided the doctor would not do it again.

The reason for that, in the smaller centres, in cities with perhaps a population of 30,000, or something of that kind, it is practically impossible to get a jury,

where some person on the jury, even if not a patient himself of the doctor, some member or members of his family have been, or his parents, or the children, have at one time or another been patients of the doctor.

SENATOR HOWDEN: That is a good thing to know. I am a doctor myself.

Mr. MATHEWS: I think that every reputable doctor will agree very largely with what I am going to say. The result is that from the practical standpoint, it is almost impossible to proceed against a doctor charged under Section 6 of the Act.

The CHAIRMAN: What do you suggest?

Mr. MATHEWS: What I am suggesting is this: the alternative, under the Act, is that you can proceed by summary conviction, in which case it comes before a magistrate. If you proceed by indictment, the accused has the right to elect trial before a magistrate, or judge alone, or with a jury, and, for the reasons I have indicated, the accused doctor will almost invariably elect to be tried by a jury, in the smaller centres.

Therefore, if you are going to secure a conviction at all, you have to proceed by summary conviction. And here is where we run into what I think is a great injustice. If an addict who in the final analysis—despite what we think—is to be pitied, and is found in possession of perhaps a minute quantity of drugs, perhaps only one capsule, or perhaps only a spoon which has not been washed out thoroughly, and there is a small residue left on the spoon, the mandatory jail term is at least six months. But a doctor, who, by reason of his standing in society and by reason of the knowledge he possesses, should be one of the best persons in a community to know the terrible effects of the use of drugs, will take advantage of the immunity he receives as a doctor to be handling drugs, and then sells them to the drug addicts and the peddlers, simply for the large amount of money he may receive for it, to my mind, is worse than the peddler, and yet, under the Summary Convictions provisions in the Opium and Narcotic Drugs Act, if he is convicted on summary conviction of selling drugs, he can get off with a fine.

Senator LEGER: Have you had many such cases?

Mr. MATHEWS: I have had several cases where I have had to prosecute doctors in different parts of Ontario.

There was one jury case we had in Toronto several years ago, where the accused was convicted.

We had a case up around Owen Sound, where a doctor was tried before County Court judge, and was convicted.

We have had several cases in other parts of the province in the smaller centres, where the doctors have been acquitted by the juries.

The CHAIRMAN: What would the fine be?

Mr. MATHEWS: If they were proceeding with a summary conviction case, I felt it might be unfair to change that and proceed by indictment, but my suggestion is that if you proceed against a drug addict for possession, there is still the mandatory minimum sentence of six months, but it seems to me most unfair that a doctor, who is convicted of peddling, can escape with a fine.

Of course, they can also receive a jail term.

SENATOR STAMBAUGH: What would the minimum fine be?

Mr. MATHEWS: The Section provides that upon summary conviction, a fine not exceeding \$1,000, but not less than \$200, or to imprisonment.

SENATOR HODGES: You would not allow the possibility of a fine?

Mr. MATHEWS: I would not allow the possibility of a fine in the case of a doctor or trader charged with peddling drugs. I believe he should be treated the same as an addict.

SENATOR HODGES: You mean the elimination of all references to fines, but automatically subject him to imprisonment?

Mr. MATHEWS: Yes.

Senator HODGES: And you think that would meet the case?

Mr. MATHEWS: I think a doctor who is trafficking in drugs should get at least the same minimum sentence that the addict receives for possession of perhaps only one capsule.

Senator TURGEON: What is the charge for selling drugs?

Mr. MATHEWS: The charge, under Section 6 of the Act, reads:

Every person who prescribes, gives, sells, or furnishes any drug to any person, unless required for medicinal purposes—

in every case we have had abundant evidence that the doctor had sold to a person whom he thought was either an addict or a pedler. In fact, on one occasion, it was sold to a member of the Royal Canadian Mounted Police, working under cover, posing in some cases as an addict, and in other cases as a pedler.

Senator HOWDEN: But we must remember that the doctor is under tremendous temptation. A patient comes in with all the signs of suffering from withdrawal, and the doctor, out of the goodness of his heart, feels that some relief should be afforded, and he gives him a "shot".

Mr. MATHEWS: That is alright. He can administer it to him. That is perfectly legal.

Senator HOWDEN: As long as he does not charge for it?

Mr. MATHEWS: Oh, he can charge a fee, yes. But if he sells 500 capsules to a man to take away with him, that is different.

Senator HODGES: Would the undercover man show any signs of addiction?

Mr. MATHEWS: What he does is make a bargain. He says, "I will take 500 capsules for such-and-such money". We are not concerned about that situation at all, because that is covered.

Senator HORNER: Is there a check on the supply to be used by doctors?

Mr. MATHEWS: The Department does endeavour to maintain a check if it appears a doctor is using more than a certain quantity of drugs. Some doctors in their practice use quite a substantial amount, while others use very little. The only thing the Department can do—they cannot necessarily question a doctor, but they can ask for a statement of what he is doing with it.

Senator HORNER: Have you had any cases of veterinary surgeons?

Mr. MATHEWS: I have not had any, but I believe there are a few.

Mr. LIEFF: Have there been any cases where the undercover man has made it quite clear to the doctor that the stuff was for re-sale?

Mr. MATHEWS: I do not recall that. Certainly I do know that in some cases, he has told the doctor he was a pedler, and wanted to get a large supply, because he had connections where he could sell it in smaller quantities.

The CHAIRMAN: The doctor should have some idea, from the quantity the man was trying to get.

Mr. MATHEWS: Oh, yes. In most cases, where the doctor was acquitted by the jury, they no doubt knew that the quantity was sufficiently large so that a mere addict would not be getting that quantity. Obviously, the undercover man does not go to a doctor and say, "I am a member of the Royal Canadian Mounted Police, and would like to buy some drugs".

Senator HORNER: Even if acquitted by a jury, the doctor has received a considerable amount of punishment from the loss of his practice?

Mr. MATHEWS: One would naturally think that. But I followed one who had been operating a branch of the profession in other respects, and apparently the publicity he received did him a good turn, because his practice nearly doubled. I cannot understand it, but it is a fact. I will not give the name, because the Press is here, but I am sure some of those here today will know to whom I am referring.

Senator LEGER: It would be an illegal practice?

Mr. MATHEWS: He was suspected considerably of being an abortionist.

Mr. LIEFF: Would this convicted physician also be struck off the rolls of the Medical Society?

Mr. MATHEWS: I believe so. We have no control over that. That is up to the medical bodies.

Senator HODGES: That is only after conviction.

Mr. MATHEWS: Yes. I know one case I had some fifteen years ago, where a doctor was tried before a judge in Toronto, and in my opinion,—with great respect—the judge leaned backwards a bit too far, and acquitted him. This doctor had come from a good family; in fact, his father was still a practising physician, but the judge, although he acquitted, gave instructions that the evidence be transcribed and forwarded to the Medical Council. Just why, I do not know. If he was innocent, the Medical Association had nothing to do with it.

The doctor was since convicted on other charges, and I believe is now dead.

I do not want to take up too much of your time, and that is the only recommendation I would like to make, because it seems to me most unfair that an addict should go to jail for the possession of one capsule, but lets a doctor who is trafficking in a much bigger way, get away with a fine.

Senator HOWDEN: He probably was an addict himself.

Mr. MATHEWS: Oh, no. None of the doctors to which I have referred were addicts. They did it purely on a commercial basis, to make more money.

There is one other matter I would like to suggest. One of the biggest problems in the drug traffic is to get the top men, who really are the traffickers. That is a terrific problem.

The CHAIRMAN: We would like to hear your views on that.

Mr. MATHEWS: I will point out some of the difficulties, if I may. I would like to say that in my opinion—particularly in Toronto, where I have had most of my experience in this work—there is no doubt whatever that a tremendous amount of credit is due to the two police forces, the Royal Canadian Mounted Police and the Toronto City Police Force. In many cases I have had, the police work they have done has been just magnificent, and I know they would like nothing better than to get some of these traffickers.

But here is the difficulty. We have caught some of the bigger ones. Some of them are in Kingston, and I have had the pleasure of prosecuting them. But we must bear these factors in mind.

In the first place, the "king pin", if we can call him that—the top man—probably during his entire career, never has any physical possession of any drugs, never touches them, nor sees them. They are handled by subordinates. The top man may be contacting other countries, and having it brought in. He may have it sent from here to Vancouver. The business of the distribution is largely conducted by telephone. We had one woman who was sent to Kingston, and she had what they call "runners" who distribute the drugs to different parts of the city, and cache it at the foot of hydro poles or telephone poles, or in some location like that, and if some addict telephones up and then pays over some money, there will be no drugs in the house, but she will say to the addict, "Go to such-and-such a lamp post, and you will find it". That

is after paying the money, of course. Of course, if the place be watched, the addict is caught, and then receives his penalty, but the real distributors have none of the drugs, and it is difficult to catch them.

Another difficulty is that it is very difficult to get the proper evidence to lay before a court in cases against traffickers. Before you can even put a trafficker in the position where he has to go into the witness box and be cross-examined—in which case you would get a great deal of information, and break him down—you have to establish a *prima facie* case, and very frequently the drug pedler will refuse to go into the witness box, and then, of course, there is the doctrine of innocence until proven guilty, and that of reasonable doubt. All that makes it very difficult.

If I can cite one particular case which was tried before Judge Forsyth, whom we had at luncheon today—and, incidentally, before dealing with that, I would say I have the highest regard and respect for Judge Forsyth. He has been of wonderful help in the enforcement of this Act, and all others of our criminal law, but there is one statement he made “off the cuff” today, which I believe may be misleading. It may not be to the members of the Committee, but with great respect, I cannot agree with him, because it is not borne out by the facts.

Senator HODGES: Should this be on the record, if it was “off the cuff”? Would it be fair to the judge?

—Discussion regarding the advisability of recording the testimony—not reported, by direction of the Chairman.

Mr. MATHEWS: I might leave out the statement made by any person, and make this statement, that in my experience—and I think in the experience of the police throughout Canada—the bank robbers, hold-up men, and others of that kind, are not, except in extremely rare cases, committed for addiction, but are under the influence of drugs. We have a great deal of crime committed in Canada which is directly attributable to drug traffic, those committed by addicts who want the money to purchase drugs, but the violent crimes are not the ones they usually resort to. In the case of men, it is more shoplifting, petty larceny, possibly fraud or pickpocketing, but they are not the ones who usually commit crimes of violence.

The CHAIRMAN: We have been so informed.

Mr. MATHEWS: I do not want that impression to get out. You very often see in connection with a bank robbery, or some violent crime, that the men were “hopped up.” That is not borne out from experience.

I wanted to correct that. If I may, I want to mention one particular case which was tried before His Honour Judge Forsyth, which was a case involving a man with a lengthy criminal record. I had prosecuted him previously for selling drugs. He was not an addict. He served a long sentence in Kingston Penitentiary for a case, and within the last year he was charged, with some others, for conspiracy to be in possession of drugs, and also for transporting them. That was under the old act.

The circumstances, very briefly, were that at a house near Gravenhurst, Ontario, a large quantity of drugs was found, and not only the drugs themselves in bulk form, but a large quantity of gelatin capsules, and a quantity of contraceptives, which are commonly used for containing drugs, chemists' scales, and that sort of thing. They were found in this house. The man in question was not an addict, but there was no doubt whatever that he was working with others. This man, whose name was Dorland, was charged. The man who owned the house in Gravenhurst was charged with possession, convicted, and sent to Kingston Penitentiary. But in regard to Dorland's connection with the case, it was our opinion he was the ringleader, but what happened was that the only evidence we had consisted of, firstly, the fact that Dorland had on two

occasions visited this same house in Gravenhurst, and they had gone into an unused attic, where these drugs were found, together with this other paraphernalia, and they had gone up there on two occasions.

Then there were two letters produced which were found by the police at the home of this man near Gravenhurst. The finding of these letters was very good police work. The letters were identified, one as having been written by Dorland.

I would like to tell you what these letters said. They are worded in the type of English they use, but they do not say "send us some drugs".

The first letter was undated, but we found the envelopes which were post-marked within the period charged in the indictment. The letter read.

"Hello M."—

The man's first name was "Murray". Incidentally, the letter was addressed to his wife, but was never picked up by her. The letter goes on:

You should have the letter by now, so here is another. Do not write me any more, as I am changing my address. I will wire Max—"

One of the other men charged—:

—100 next week for you. In the meantime, I want a 7 to three done up with the cap's on, or as many as you can do, have them ready and I'll get in touch with you at week's end, as I won't be here you will have to tell Max when they get off, I will phone him I'll write again with the destination hope kay is well. things look a little brighter.

yours B.

That was signed "B". That was post-marked "Vancouver" and Dorland happened to be in Vancouver at that time.

The second letter read this way:

"Hello M: Got over my journey o.k.—"

This was also post-marked "Vancouver".

—cant tell much about things yet, got your note I was disappointed in the amount but Ill have to straighten it out on this end. that destination no good for notes to me as I never see those people, just the amount is enough. let call that, No 1 address. this address will be No 2 they are another outfit. I want this order filled, on this address. Mr. Dave Lockerby R.R. 1 or 2 Langley B.C. the 1 or 2 means that either route ends up there.

5 Brown Bolts in 5 separate pieces, 30 gr's

5 piece done up better make them all 30 gr's

3½ Brown to 1½ M.S.

P.S. let Max have his stuff out of the big parcel. the littl half I will probably get rid of first I will look after you next week. Send this as fast as you can."

It is signed "Bob".

The "brown" refers to Mexican heroin, and a "bolt" is usually an ounce of heroin, which is a large quantity.

That was the extent of the evidence from our knowledge of what was going on. We felt this chap was actually handling it. He was charged with conspiracy to be in possession of drugs, and to transport drugs from Ontario to British Columbia.

The Judge acquitted him, although I think it was a border-line case. On the other hand, there are so many defences which can be raised. For instance, the defence could very well argue, "Supposing, in the first place, they did not mean drugs". Anybody with experience would know that was it. Supposing

the defence takes the position, "Well, maybe it was drugs, but that does not show there was a conspiracy to be in possession. He might have somebody in Vancouver who wanted to buy some drugs, and he wrote this man and told him to send them, and he would pay for them". Then it would be a vendor and purchaser transaction.

All these are technical defences which makes it extremely difficult to get a conviction, bearing in mind the secrecy with which these things are done, and the fact that the Crown has to prove the guilt of the accused beyond a reasonable doubt. That puts a very onerous task on the prosecution.

Those are some of the difficulties. There are a few more very concrete suggestions I would like to make, and present to you for your consideration, in case you are recommending any change in the Opium and Narcotic Drugs Act. They are not all one category.

Firstly, under the Opium and Narcotic Drugs Act, there was a certain onus section, and that certain evidence will be *prima facie* evidence. For instance, under Section 15 of the Act, it is not necessary for the prosecution to establish that the accused did not have a license, and if he alleges he did have a license, then the onus is on him to establish that. That is there now, and has been for years. But that applies to prosecutions under the Opium and Narcotic Drugs Act only.

Supposing a man is charged with conspiracy to sell drugs or be in possession of drugs. That is under the Criminal Code, a conspiracy to commit an indictable offence, that of selling drugs, contrary to the Act, but because it is under the Criminal Code, being a conspiracy charge, this onus section does not apply to it. Therefore, the Crown has to do a great deal of unnecessary work to secure affidavits from Ottawa, showing the accused did not, in fact, have a license.

My suggestion is it would not be a hardship on the accused, and would simplify the prosecution, if that section were amended to include not only a charge under Section 4, but a charge of conspiracy to commit an indictable offence, under the Opium and Narcotic Drugs Act.

The same would apply to Section 17 and Section 18.

Section 17 is the onus section, and provides that where a person is charged under Section 4, any person who occupies, controls, or is in possession of a room, building, vehicle, enclosure, and so on, where a drug is found, if he is charged with possession, is deemed to be in possession of that drug, unless he proves it was there without his knowledge, authority or consent.

That is a very useful onus section, because, after all, if you were found with drugs in your room, in a rooming house, or a hotel room, or your own home, or your motor car, and you do not know anything about it, it is easier for you to show that, than for the Crown to show what was in your mind, and how it got there. That has been in for years, and again it does not apply to a charge of conspiracy.

I think, similarly, where there is a charge of conspiracy to be in possession of drugs, it is just as reasonable that the onus section should apply.

Finally, Section 18 provides that in a prosecution under the Opium and Narcotic Drug Act, the certificate by the Dominion Analyst that the substance in question was, in fact, a narcotic drug, and specifies it, is *prima facie* evidence that it was. Again, that is open to the defence to rebut that presumption of guilt, by evidence to show that it was not. That is very useful. Otherwise you have to call the Dominion Analyst as a witness in every case.

My suggestion is that again should be extended to a charge of conspiracy to commit an indictable offence under the Opium and Narcotic Drugs Act.

My final suggestion is this: as I say, it is so extremely difficult to secure evidence beyond a reasonable doubt against a trafficker, because of the very

secrecy with which they carry on for the reasons I have outlined. I have tried to consider if it was possible to simplify the task and put him on the defensive to a certain extent.

As you know, in most criminal law—although there are exceptions—the onus is on the Crown to prove the commission of the offence beyond a reasonable doubt. There are exceptions, as I say. For instance, under the Liquor Control Act, and under the Official Secrets Act, and under the Customs and Excise Act, there are some exceptions, such as Section 17 under the Opium and Narcotic Drugs Act.

I am presenting this for your consideration. It is a drastic departure from the ordinary principles of criminal law, but I believe unless something drastic is done, you will not get the top traffickers in these cases.

I was trying to give some thought to the matter yesterday, and it occurred to me this is something to which you might at least give consideration.

I will read it to you. It is reasonably drastic, but, as I say, I think it might make it more possible to get the big traffickers.

I am suggesting an amendment, in the following words:

“Where a person is charged with an offence against Section 4, subsection 3 of this Act— —”

That is the offences of either trafficking in drugs, or possession for the purpose of trafficking — —

— — or with conspiracy to commit an indictable offence under Section 4, subsection 3 of this Act, and evidence is given which furnishes a reasonable ground for believing that an accused may be guilty of the offence as charged, then the onus shall be on the person so charged to prove that he is not guilty of the offence as charged, and failing such proof, such person shall be convicted of the offence charged.”

What I am suggesting here for your consideration is whether it would not be advisable, in the case of trafficking—it does not apply to the other offences—or possession for trafficking, to make the onus shift, and not require the Crown to prove a person guilty beyond a reasonable doubt, so he can sit back and not get into the witness box.

Senator LEGER: He would have to prove otherwise?

Mr. MATHEWS: Yes.

Senator HODGES: He would have to prove his innocence?

Mr. MATHEWS: Yes, he would have to prove his innocence. In other words, instead of you having to prove beyond a reasonable doubt that he was guilty, once you prove there is reasonable grounds for believing he is guilty of the offence, then the onus shifts to him. In other words, it is about the same as in a Civil case, with regard to the balance of probabilities, and is very much the same onus as a person's insanity as a defence to a criminal charge.

If such a provision were in the Act, I think it would be easier to get the top traffickers. For instance, if Dorland had had to go into the witness box, he would have had a hard time talking his way out of those letters, and his visits to the other man's house.

Senator TURGEON: Where is Dorland now?

Mr. MATHEWS: As far as I know, he is at large.

Senator TURGEON: How long since this case occurred?

Mr. MATHEWS: I cannot tell you exactly; the offence took place about 1952, but they could not apprehend Dorland for a matter of a year or two, so the case was not tried until last August.

I am afraid I have kept you too long. Those are just some suggestions I wanted to make. If there are any questions any honourable member of the Committee would like to ask, I will try to answer them, at least.

The CHAIRMAN: Has any honourable Senator any question to ask of Mr. Mathews?

Senator HORNER: Just one question, Mr. Chairman. The means of livelihood enters into the case, does it not?

Mr. MATHEWS: It would, if the accused were in the witness box. Then you can cross-examine him as to his means of livelihood, but the trouble is to get him there.

Senator HORNER: The trouble is to get him there?

Mr. MATHEWS: Yes. If you do not get him into the witness box, you cannot ask him anything—obviously.

Senator HODGES: You say this does apply in other cases?

Mr. MATHEWS: Not in the same words, but the reversal of the onus of proof does apply in a number of cases.

Senator LEGER: In civil cases?

Mr. MATHEWS: The onus is on the plaintiff, and it is known as the "balance of probabilities". But in a criminal case, the Crown has to prove the guilt of the accused beyond a reasonable doubt, and it is sometimes very difficult to do that, because if you can conjecture any other possibility which may be considered to be feasible at all, then, of course, the judge and the jury may have some doubt.

The CHAIRMAN: Mr. Mathews, may I on behalf of the Committee thank you for your presence here today, and for the information you have given us. We appreciate it very much.

Mr. MATHEWS: Thank you, Mr. Chairman and Senators.

—Mr. Mathews retired

The CHAIRMAN: Our next witness this afternoon is Colonel Ervin Waterston, Secretary for Man's Social Service, of the Salvation Army

I will ask Colonel Waterston if he will please come forward at this time.

Colonel ERVIN WATERSTON (*The Salvation Army*).

The CHAIRMAN: Will you please proceed, Colonel Waterston?

Colonel WATERSTON: Mr. Chairman and honourable Senators; my presentation will follow the lines of the methods used by the Salvation Army, in connection with the use of drugs.

The use of narcotics, or drug addiction as we now call it, as well as alcoholism are, in the opinion of The Salvation Army, serious lapses of the moral code and therefore, their use is a sin and not a disease as some would have us believe. Quite true, the addict's physical body may come to such a state as to have many semblances of disease but its beginnings are in the violation of the moral code laid down for the guidance and direction of the human race.

It was because there are multitudes of people addicted to these vices, as well as other social evils, that the Founder of The Salvation Army, William Booth, laid down a well thought out plan for Social Work. This plan was first made public in his book "Darkest England and the Way Out" which was published in the year 1890. The fact that many editions of this book have had to be printed to meet the demand for a reference text book for professional Social Workers and others is a tribute to the remarkable insight and forethought of its Author in dealing with the problems that affect the welfare of mankind.

William Booth's plan has resulted in a great chain of Social Institutions in every land in which The Salvation Army operates. The Social Work is an attempt to fulfil the commands, with which the Scripture abounds, to remember and assist the weaker members of our society. The Social Worker is a powerful agency for reaching the hearts and consciences of multitudes in every nation, who, without its help, would be practically abandoned to despair.

The object of Social Work is the amelioration of the condition, and the salvation for this world, and the next, of those members of the Community who are at present the victims of poverty, vice, crime, or those who are in danger of becoming such. These classes are sometimes spoken of by The Army as the "submerged" and comprise among others the workless, destitute, alcoholics, drug addicts, and others. To deliver these classes from their wretched condition, and to bring them into harmony with the character and purpose of God, is the aim of The Salvation Army.

The Salvation Army proposes to accomplish the objects set forth above, insofar as it is furnished with personnel and means, by:

- (a) Supplying the immediate necessities of the people, by,
 1. Feeding the hungry.
 2. Clothing the naked.
 3. Housing the homeless.
 4. Healing the sick.
- (b) Changing the evil habits of those constituting the varied classes to be helped, which will mean among other things:
 1. Making the drunkard sober.
 2. Curing the drug addict.
 3. Making the loafer work.
 4. Making the criminal honest.

All this means, in general terms, saving these suffering people from the evil habits that have brought about their miseries.
- (c) Bringing hope to those who are in despair.
- (d) Removing such as suffer from temptations too powerful for them to resist, into conditions more favourable to a true, honest and religious life.
- (e) Placing them in circumstances in which they can earn a sufficient livelihood either in their own or some other community.
- (f) Restoring prodigals, profligates, and runaways to parents, husbands, wives and friends.
- (g) Bringing, so far as it is possible, the pauper, vicious, and criminal classes and the multitudes who suffer with and on account of them, into the enjoyment of the Salvation of God.

I. *The first principle* on which The Army founds its hopes for the reclamation of the drug addict, or other victim of Satan's wiles, and their permanent deliverance is—"the salvation of the individual through faith in Jesus Christ". This is not a condition on which The Army admits these unfortunates into its Institutions but is the chief ground on which The Army builds its hopes of accomplishing their deliverance. If they get into a right relationship with their Creator, other blessings are sure to follow:

- (a) The working of this principle involves:
 1. Repentance toward God, which means the discovery of the deadly character of sin, and its voluntary abandonment.
 2. Forgiveness, which reconciles man to God and gives the assurance that He is his Father and Friend.
 3. Conversion, which means a change of heart and life by the power of the Holy Ghost, so that bad habits will be exchanged for good.

- (b) This change of heart when effected produces truthfulness, honesty and industry—qualities which seldom fail to secure work and comfort and friends for all.

II. *The second principle of Social Work is the co-operation of the individual whose benefit is sought.* Without that co-operation it is unreasonable to expect success. To make this co-operation a reality:

- (a) *Confidence must be secured.* It is difficult at times to make these poor creatures, often abandoned by society, believe in the organizations's disinterestedness, but once that confidence is established, half the battle is won.
- (b) *Hope must be created.* So long absent from their lives, many of the outcast have come to regard hope as having fled forever. It must be brought back. Little can be done with a heart that is constantly giving way to despair.
- (c) *Deliverance must be made to appear possible.* The first stretch of the march must be made as easy as possible and all the encouragement necessary should be given at all times.

III. *The third principle of Social Work is the introduction of the sufferer to more favourable conditions of life:*

- (a) If he is hungry, and naked, and homeless, he must be supplied with food and clothes and shelter.
- (b) If he is a slave of evil companionships, he must be persuaded to abandon them and seek helpful companions.
- (c) If he is so weak to be the creature of circumstances, and his circumstances are such as to make him bad, or vicious, pity should be shown him and an effort made to change his surroundings.

IV. *The fourth principle of Social Work is the provision of some useful form of labour in which the individual can engage:*

- (a) He should work for his own benefit, apart from the question of financial necessity. If there were sufficient funds in the treasury to maintain the whole fraternity without labour, to keep the man in idleness would be to inflict an absolute injury upon him.
 1. Work is reformatory.
 2. Work is essential to health.
 3. Work is the great spirit reviver.
 4. Work is the doorway to a happy future.
- (b) A work program, such as carried on in The Army's Institutions, is essential to the success of the undertaking, since by it those who participate can at least contribute towards the cost of their own deliverance, thus making them largely independent of charity.
- (c) The work undertaken should be useful, remunerative, and congenial insofar as is possible.
- (d) If the individual is unskilled in any form of labour he should be taught some form of skill.
- (e) The reward given for labour should be proportioned to the workers' industry and aptitude.

V. *The fifth principle of Social Work should be the practical exercise of love.* The exercise of human love has accomplished blessed feats of valour in the past, and the principle is as powerful today as ever it was.

The Salvation Army has no quarrel with such organizations as Alcoholics Anonymous, Narcotics Anonymous, and those using such remedies as Anti-buse, etc. In fact we frequently have occasion to work in co-operation with them but we do feel that the most successful remedy of all is that process of

spiritual therapy which I have attempted to outline. We do take serious issue with those people who advocate the setting up of free clinics to dispense narcotics to those already enslaved by that vicious habit.

The Army has found that drug addicts, alcoholics, etc. are greatly helped by a right form of diet, regular sleep and rest, plenty of suitable recreation, suitable friendship, good music, religious services, Bible Study and prayer meetings. The individual should be encouraged to take part in all these activities.

Permit me to give you just three instances of how this spiritual power works:

- (a) Joe—— came from a broken home and started thieving at a very early age, with the result that he was frequently committed to custodial Institutions, and at the early age of 16 years was committed to a Canadian penitentiary. Whilst there he was introduced by a fellow prisoner, to the use of narcotics. When released he had become an addict and continued to steal in order to provide the wherewithal to buy more drug. While waiting trial on some of these charges, a Salvation Army Officer found him lying on the floor of his room completely under the influence of drugs. He was taken to our Centre, in the city of Calgary, where treatment began. After some weeks he came forward to our Penitent form in one of the services held in the Centre. There he prayed to his God for a change of heart and his prayer was answered for from that hour Joe was a changed lad. That Salvation Army Officer is now in charge of our Harbour Light Corps in the city of Toronto and two months ago received a letter from Joe who is now, although only twenty-four years of age, a happily married man with one child and is a trusted employee of a large Calgary corporation. Joe states "even the desire for drugs is gone. I really do thank God for making this change in my life".
- (b) Mike—— had been a victim of alcohol and dope for many years. Sick in mind and body he appealed to The Salvation Army in Toronto for assistance. He was too ill to work at a regular job so he was given a light task in our Centre. Good food, restful sleep, comfortable housing, and sincere friends soon made their effect on Mike quite plain and he began to take heart and enjoy the religious services held in the Centre. He soon decided to try the christian way and in one of these services, he was one of those penitents kneeling at the Army's Penitent form. He trusted God's power and became a new creature free from the desire for narcotics. Mike has now graduated from the Centre and is doing well in a neighbouring community.
- (c) Jimmy—— was a hospital orderly and became addicted to alcohol, and later started to take drugs, and soon found himself a regular habitant of Toronto's 'skid-row', when he was not languishing in jail. I quote Jim's own words:

I came to The Salvation Army in very bad shape trying to fight booze and dope that had me beat. After holding down a good job for a number of years I lost that through my addiction to alcohol and drugs, and like so many other men I ended up on skid-row. Many years were spent in and out of jail. In that condition I came to The Salvation Army Hostel where I was kindly received and hear the message of salvation and the testimonies of men who had been as bad as I, but whose lives had been changed by the wonderful power of God through Christ Jesus. I listened to all this and will never

forget the night when I accepted Christ as my personal Saviour and experienced a real change of heart. I thank God for the peace and contentment that has come to me as a result of that experience.

The Army arranged for Jim's transfer to another city, and secured suitable employment for him. He is no longer a public charge or problem to society but is accepting all the responsibilities of good citizenship in the community in which he now lives.

A relatively small number of the great army of victims of these vices seek the assistance of the Salvation Army, and not all who do seek our help gain that victory which we so earnestly desire for them, but we do believe that our program is sound and when sincerely put to the test is capable of a very high incidence of success. There is need for many more Institutions, such as ours, and for an army of devoted and consecrated workers who will seek to understand the problems of those unfortunate people. It would be our hope that the Government of this fair Canada would assist in setting up more such Institutions and provide financial assistance to existing Institutions to enable them to intensify and expend this type of work. Not only are treatment Centres urgently needed but a program for after-care and job placement is a vital necessity.

We value the opportunity of placing these observations before the Senate Committee and would record our assurance of our willingness to continue in fullest co-operation in public service aimed at helping to remove social evils; accomplishing the physical, moral and spiritual rehabilitation of men and women, and securing the highest good for the greatest number of people in our nation.

The CHAIRMAN: May I ask you a question, Colonel Waterston? Speaking of these addicts, would the number you have successfully taken care of outnumber the failures?

Colonel WATERSTON: By many times, sir.

The CHAIRMAN: It would?

Colonel WATERSTON: Yes, sir.

The CHAIRMAN: Do the honourable Senators wish to ask any questions of Colonel Waterston?

Senator TURGEON: Do you meet the drug addicts when they get out of a mental institution or an institution of any kind?

Colonel WATERSTON: We do meet them.

Senator LEGER: In fact you visit them when they are in jail?

Colonel WATERSTON: Yes, we come in contact with them, in almost all circumstances.

Senator HORNER: Do you express any desire to continue hearing from them?

Colonel WATERSTON: We have a follow-up program which we felt was necessary for them in connection with their rehabilitation.

The CHAIRMAN: You think that is vital ?

Colonel WATERSTON: Very vital.

Senator HORNER: We have had complaints that young people come out of the Toronto jail, and there is no one to meet them, no one to offer them work; they were simply turned loose on society.

Colonel WATERSTON: I might say the Salvation Army visits every penal institution in Canada practically every week, and sometimes more often than that. I know that the Oakalla Jail is regularly visited. The inmates are visited

while in the jail, and invitations are extended to them to let us know when they are coming out, and we will meet them at all times, if we know when they are coming.

The CHAIRMAN: Are there any other questions, honourable Senators? (No response) If not, Colonel Waterston, may I thank you most sincerely on behalf of the Committee for coming here. I assure you we appreciate it.

—Colonel Waterston retired.

The CHAIRMAN: Honourable Senators, the next witness has been brought forward by Miss Parker, of the Elizebeth Fry Society. She is bringing forward a female addict, and, of course, no names will be used.

Mr. LIEFF: Miss Parker will have nothing to say, Mr. Chairman and gentleman.

Female ADDICT (hereinafter known as "Mrs. 'X'") appearing under the auspices of the Elizabeth Fry Society.

Mr. LIEFF: Mr. Chairman and honourable Senators; yesterday I had the opportunity of having a conversation with the witness, and perhaps I might give just a little background, although you may agree or disagree with what I say.

I understand from the witness that at an early age in her life, the witness was not getting along well at home.

Mrs. "X": Yes that is right.

Mr. LIEFF: And had been living with friends and relatives, and a little later ran across some friends who were drug addicts?

Mrs. "X": Yes.

Mr. LIEFF: And I think you told me that prior to your going on drugs—that was at what age?

Mrs. "X": Sixteen.

Mr. LIEFF: That you had been in Juvenile Court?

Mrs. "X": Once.

Mr. LIEFF: For some minor thing?

Mrs. "X": Yes.

Mr. LIEFF: Breaking a window, or something like that?

Mrs. "X": Yes.

Mr. LIEFF: And you went at the drugs pretty hard?

Mrs. "X": Yes, I used them all the time when I was out.

Mr. LIEFF: You were not what was called a "joy popper"?

Mrs. "X": No. As soon as I started using drugs, I kept right on using them. I never used them for awhile and then quit and started again. I started right in, and that was it.

Mr. LIEFF: I think you said you were "all mixed up", and thought that taking drugs would be the answer to your problem?

Mrs. "X": I think everybody who uses drugs is "mixed up".

The CHAIRMAN: How did you know about the drugs?

Mrs. "X": I was supposed to be going to school, but I went downtown, and when you play "hookey", there is only one place to go, and that is to the worst part of the city. There you run into people. I was fascinated by them.

Senator HODGES: With what drug did you start?

Mrs. "X": Heroin.

Senator HODGES: Have you always used that?

Mrs. "X": Yes.

The CHAIRMAN: How did the first "shot" hit you?

Mrs. "X": I thought it was wonderful. The person who gave it to me first knew about it, so I was not sick.

Mr. LIEFF: What was your maximum habit at any one time?

Mrs. "X": From eight to ten caps a day.

Mr. LIEFF: What would be the most expensive day you had, supporting your habit?

Mrs. "X": Well, that is hard to say, because whatever money I had, I used for drugs. If I had \$4.00, I bought \$4.00 worth, and if I had \$20.00, I bought \$20.00 worth, and if I had \$100.00, I bought a \$100.00 worth. Whatever money I had, I spent on drugs.

The CHAIRMAN: You kept a supply on hand?

Mrs. "X": Yes.

Mr. LIEFF: How did you support your habit? By thieving?

Mrs. "X": Mostly.

Mr. LIEFF: You have had a number of convictions?

Mrs. "X": I have five convictions for narcotics.

Mr. LIEFF: And you have been off drugs now for how long?

Mrs. "X": I was arrested on July 30th, 1953, and I got out on the 28th of January, of this year.

The CHAIRMAN: Are you working?

Mrs. "X": Yes. I have been working ever since I got out.

Senator HODGES: Have you been taking drugs since?

Mrs. "X": No, I have not.

The CHAIRMAN: Do you live at home?

Mrs. "X": No, I live with myself. My family is not at home.

Senator HODGES: Do you feel you have got over the drug habit?

Mrs. "X": I think I have. Of course, if something upset me, I might go back, but at the moment I do not think I will ever use drugs again.

Senator LEGER: You have no desire for them?

Mrs. "X": Not now.

Mr. LIEFF: But you have had no feeling against it before?

Mrs. "X": Not before.

Senator LEGER: Did you have any spiritual assistance?

Mrs. "X": No.

Senator HODGES: What is the longest time you have been off drugs?

Mrs. "X": When I got out of jail, I went off the drugs immediately.

Mr. LIEFF: And how long would it take you to get drugs?

Mrs. "X": Oh, probably five or ten minutes.

Senator LEGER: When you came out of jail, you had no money?

Mrs. "X": They give you \$20.00 when you leave.

Senator HODGES: Is it a fair question to ask you what induced you to change your point of view this time?

Mrs. "X": Oh, a lot of things.

Mr. LIEFF: Do not be afraid to speak up.

Mrs. "X": It is not that. It is that I am trying to word it right.

Senator LEGER: You were "fed up" with the life you were living before?

Senator HOWDEN: Did you ever have the fear of not being able to get drugs?

Mrs. "X": No.

Senator HODGES: If it is possible for you to tell us what led you to change your point of view, it would be of great help to the Committee.

Mrs. "X": There are so many things. I guess I just suddenly realized that I was going to spend the rest of my life in jail. I had been using drugs for nine years, and I spent about seven of them in jail. The Elizabeth Fry Society helped a lot.

Senator HODGES: It did?

Mrs. "X": Oh, definitely. I could not have done it without them.

Mr. LIEFF: You have come to try and help solve the problem. What suggestions do you offer?

Mrs. "X": I think clinics are a very good idea.

Mr. LIEFF: Where it would be easier for the addicts to get drugs?

Mrs. "X": Not necessarily because it would be easier to get them, but because if the addicts were getting drugs legally, nobody would be hurt.

Mr. LIEFF: Your suggestion is to have clinics—

Mrs. "X": I do not say to hand them out to everybody. It should be regulated.

Senator LEGER: If you had clinics, would you go back to drugs?

Mrs. "X": No. I think if there were clinics, there would not be as many people using drugs.

The CHAIRMAN: Why?

Mrs. "X": The way it is now, if you start using drugs, you cannot work and use drugs, because you cannot afford it. If a person is working every day, and getting drugs legally, it stands to reason they will say, "Why use drugs?"

There would be no necessity for them to go out and steal. They might just as well be living normally, as only living half and half.

The CHAIRMAN: Do you think under a system of that kind, it would be possible for the drug addicts to obtain a supply? Say he was going out to a logging camp, would it be possible for him to get a supply, and dispose of the drugs he would receive? That has been suggested to us.

Mrs. "X": It is possible, but not probable. The people who want help will go to the clinic, and they will not help themselves, by trying to get an over-supply.

The CHAIRMAN: What about the number who might not have the mind nor the thought to be cured? We found that in one of the jails in British Columbia, where there were people who said they did not want to be cured.

Mrs. "X": I was like that for years. People asked me if I wanted to quit, and I said, "No". But I think it comes some time in everybody's life where they realize they should quit.

The CHAIRMAN: You got help at that time?

Mrs. "X": I think half the drug addicts will not want to be cured right now, but sooner or later they will want to be cured. The ones who may seem the less likely to ever be cured now, may be the first ones.

Senator HODGES: What started you on drugs? Was it your association with drug addicts?

Mrs. "X": No, not necessarily. I think people who use drugs have a fear sensation. I think they are emotionally unstable. They will use them regardless of whether they become drug addicts or not. They will do something. It is either alcohol or drugs.

Senator HODGES: But you do not get drugs as easily as you do alcohol?

Mrs. "X": No. As a matter of fact, I have met a few drug addicts, and they talked to me for hours, telling me not to, but I was determined I was going to use drugs.

Senator LEGER: You took drugs in spite of that?

Mrs. "X": Yes.

Senator LEGER: Did you use alcohol?

Mrs. "X": No.

Senator LEGER: You never did.

Mrs. "X": No.

Senator HORNER: There seems to be a misconception on the part of some people in Canada with regard to these clinics. We had a man from England, from the Health League of the United Nations, and he noticed a great many people in Canada were talking about clinics, and he said there never was and is not now such clinics in England at the present time.

Mrs. "X": In England?

Senator HORNER: Yes. He was of a very fine type. He gave us a very fine talk, and he wound up by saying in England they would not consider such a system. He said there were only about 300 addicts there, and certainly doctors would be allowed to treat the feeble or aged persons, but he felt that now, out of a population of nearly 50 million, there were only about 300 addicts, and it was no problem at all.

We heard a doctor in Vancouver say that he did not know of such a thing. He said he had never met a patient in all his experience in the Old Country—a person who was an addict. That seems to be a great reflection on our way of life in this country. We were informed there was only one known Japanese, in a country of some 80 million people, and it is no problem at all there.

Surely our Canadian people should stop and consider "Are we going to do away with the drugs, or is there something particularly lacking here?"

Mrs. "X": Do you think maybe the laws are better here?

Senator HORNER: I do not think so. In what respect would you say the law was better.

Mrs. "X": There are more convictions for narcotics here. Perhaps there are more in England "getting away with it".

Senator HORNER: Oh, I do not think so. They keep a close check on it.

Mrs. "X": I know people from England, too.

Senator HODGES: How did the Elizabeth Fry Society get in touch with you?

Mrs. "X": When I got out, they got me a place to stay and got a job for me. I get very upset and emotional about things, and I can go up and talk to them. If that were not possible, then I would probably be downtown.

Senator HODGES: You feel they have given you a great deal of help?

Mrs. "X": No doubt. If it had not been for the Elizabeth Fry Society, I am sure I would be using drugs again.

Senator HODGES: Were you met when you came out?

Mrs. "X": Yes.

Senator HODGES: They actually met you, and took you in hand?

Mrs. "X": Yes.

The CHAIRMAN: Have you been contacted by drug addicts trying to induce you to take drugs again?

Mrs. "X": I have my friends. I have been asked if I wanted drugs, and I said "No", and that was all there was to it. Nobody ever tried to tie me up or kidnap me.

Mr. LIEFF: There is a question of whether people go out endeavouring to seduce people to use drugs just to get new customers for the peddlers?

Mrs. "X": No, I have never known of that.

Senator HODGES: In connection with that; you said before, that when you came out of jail, within ten minutes you could get drugs?

Mrs. "X": Oh no, not necessarily within ten minutes after getting out. What I meant was that when I got out, if I would go downtown, I would know where to get drugs. I would find one of my friends, and that would only take me ten or fifteen minutes.

Senator LEGER: Is it too much to ask you if you go to church now?

Mrs. "X": No, I do not, I am afraid. I do not feel that would help me. There are people it would help, and people it would not. I do not believe it would help me at all.

The CHAIRMAN: Honourable Senators, have you any further questions to ask of this witness?

Senator HODGES: I would like to say that I sincerely hope this young lady will keep on as she is doing now.

Mrs. "X": I think I will.

The CHAIRMAN: We appreciate you coming before us, and I thank you on behalf of the Committee, and we hope the good work will continue.

Mrs. "X": I think I am alright, now.

—Mrs. "X" retired.

The CHAIRMAN: The last witness this afternoon is another addict.

Mr. LIEFF: The next is a gentleman about sixty-eight years of age, I had a rather interesting chat with him yesterday afternoon. I do not think there is much point in going into this man's record. He will tell you about it. He has had quite a substantial record, and has had a long time to think about his problem.

The CHAIRMAN: I understand he was formerly around the House of Commons, as a page boy?

Mr. LIEFF: So I understand.

The CHAIRMAN: Well, I will ask him if he will now come forward.

A MALE ADDICT (hereinafter known as "Mr. 'Y'").

The CHAIRMAN: Will you proceed with anything you wish to place before the Committee?

Mr. "Y": Mr. Chairman, and honourable members of the Committee; I was asked the question—and a very trite question—why I wanted to appear here. It could not have been for publicity, because I did not want my name mentioned. It is not for pay, because I do not expect to get any. It is because I have a little pride, because I wanted to show the Committee the rejuvenation of a man, and to show it is possible to bring back a drug addict, and enable him to become a decent, normal member of society.

I would like to preface my remarks by saying that I am in no way anti-social. I do not blame the world. I blame myself. I am proud of my country—

Senator HORNER: There is always hope for a man who can say that.

Mr. "Y": I think we live in the greatest piece of territory on this "old ball of mud".

My connection with drugs goes back forty years. I used drugs long before I went to prison. I started using them in an unusual way, up in the north country, where you expect to find gold, not drugs.

The CHAIRMAN: Who started you on the use of drugs?

Mr. "Y": A lady, an adventuress. I saw her smoking opium one day. Being curious, I asked her what it was, and when she told me it was opium, I was interested. I had read about the Chinese opium dens, and so forth, and I said, "Let me try that thing"—

Senator HODGES: How old were you at that time?

Mr. "Y": Just a "kid". The girl, in turn, did not want me to use it. She said, "No, it is not for you", but I said, "Go on, let me try that thing".

She gave me what would be known in the opium trade as a "green pill", that is, a pill of uncooked opium, and when I smoked it, I became very, very ill. If I had stopped there, it would have been fine, but when I found out that smoking did not make her sick, I finally got a cooked pill to smoke, and it is quite a sensation. Somebody may tell you they acquired the habit because they were given drugs during a period of sickness; others will say they got it in the jails, reformatories or prisons, and others will say—which is a point for the psychiatrists—they were given it on parties, and things of that sort, or some other trivial excuse. I kept using it because I liked it. I did not know it was habit-forming.

It was inconvenient to carry a pipe around, and what was necessary to use it, and finally the same lady showed me how to get the same kind of a "kick" without carrying the pipe around, and I became addicted to heroin powder, which at that time was—pardon the vulgar expression—"sniffed". I have been using the needle for years and years.

That went on and on, and one day out in the woods—I was down in the Temagami River district—and I did not have any of this white powder with me, and I was very sick, and I staggered over the road to South Porcupine—no doubt you all know where that is—and I went into Pottsville, and I went to see a certain person and he said, "You have been using it"; he said, "You have been 'sniffing' it", and he said, "You are now sick for the want of the drug". Being a decent fellow, he brought some out. At that time, I wondered why he had buried himself there. He gave me the drug, and then he told me his story. He said, "I am up here because I cannot hold a responsible practice. I use that stuff, and if you stay at it, you will become a big 'bum'; you will never break it completely on your own."

He was very truthful, and I went on and on and on. I started going to prison, and made some come-backs. I have no excuses. I was born on the right side of the tracks. My father and mother were wonderful people, and as a "kid", I paged in the House of Commons, and paged in the Senate, and listened to the best speakers of my era, and had a good education, and was a capable man, but drugs took it all away from me.

Time and time again I came to starting over, and attained a certain measure of success, and then the old thing would crop up again; somebody would know about it, and tell somebody else. By that time, the drug addicts had become known as the "untouchables", because we had the name of "dope fiends", and ordinarily, citizens when they read about "dope fiends", they thought they were people with long tusks, and who carried "kids" into caves, and became associated with the sex perverts. When crimes were committed, it was the common thing to say, "A crazed drug addict does so-and-so". That all hurts a man in business.

After many times in prison, and some pretty hard knocks in the prisons, I forsook that pretty well.

Away back in 1925, up in Burwash, I had a "housecleaning" up there. We were blessed by having a Minister sent up there to be the Superintendent. He was not very successful, because his heart was too big. But he was smart enough, and knew there must be same way of handling drug addicts, and he set up a camp in the woods at Burwash, which was the first one ever set up, and I know that we attained a good measure of success there. It is an old camp, which is still there—old Camp No. 5.

It became a drug addict camp, under the supervision of custodial officers, of course, and with a doctor in charge. I was the clerk and storekeeper there. We lived our own lives there. We were the ones who did not have to associate with some of the other people. Every time they segregated drug addicts, they did a good turn because they are a pretty decent type of people on the whole, when away from drugs.

We were given the withdrawal treatment, and the statement that we were given "dope" in the food is untrue, but we were told to perform the tasks required in a place of that kind—

The CHAIRMAN: What did they give as the "withdrawal treatment"?

Mr. "Y": Three weeks' injections of morphine, in those days.

Senator STAMBAUGH: And gradually getting smaller?

Mr. "Y": Yes. They used the system in the county jails, but they have done away with it now. We had to cook, and the rest of it, and keep the building clean. I can remember now fifteen or twenty men who are still living, who never went back any more. They dropped it eventually.

I understand the province is on the verge of establishing a small clinic out at Mimico, a very poor and ineffective place to put it, in my estimation. It is down in the foggy, brickyards and close to the city, where the addicts can make connection with outside drug addicts to keep them supplied with drugs. That will probably "fizzle" out.

I have had no association with drugs for over three years. I have been working now for one year. I am not holding down the best job in the world, but I am reasonably happy. I go to church—not too frequently—and I enjoy a few of the things I missed for some years, and I think there are hundreds of drug addicts who can do the same thing, provided they get the help I received.

A great deal of help came from one man, and I do not mind mentioning his name, W. J. Stewart, who was the Chairman of the Ontario Committee on the Department of Reform Institutions. He placed me in a job, through a certain machinery. He had all the confidence in the world in me. He is at my beck and call whenever I raise the telephone. If I have any problem, he will decide it for me. In turn, he got me a job through two men who knew where I had been. When they read the papers tomorrow, they will know who has been talking. They have been wonderful.

I have been reading over all the things which have been presented to this Committee. I find so many police suggestions in some cases—I do not know what went on here, but in Vancouver I would say the Chief of Police is frustrated by the problem he cannot handle, and he wants to put all the addicts on an island somewhere. I do not believe in that at all, at all. I cannot see why they should be taken away from society.

Mr. Mathews, who has prosecuted me—and successfully—on several occasions, was here today. He adopted the attitude today of a defeatist. He is a very courteous gentleman, but he wants a proper amendment to the law, to make prosecutions easier and more successful.

I think the chief thing is to try to eradicate drug addiction by providing help for the drug addicts.

Yesterday, I was asked a question, and I made a rather sweeping reply. I thought of it, when I was mopping the places I mop, but which I do not like doing. However, it is a job.

I was asked if I believed in a five-years' penalty for first-time peddlers, and I said "Yes." I am forced to make a reservation to that, and say, "Not if the peddler is an addict".

As far as the peddlers are concerned, they are the scum of the earth, but I know some addicts who have been peddlers and runners, because, to keep their habit up, they have to pay for it that way, instead of going out and stealing. I would not suggest anything to hurt them. I could not do it, because they can be saved.

But the "guy" who drives around in a Cadillac is another matter. I see one of my old friends is here, Mr. Carson. I have been arrested by him once or twice, and I think I have also appeared in front of Magistrate Elmore, who I see is also here, but in a friendly atmosphere—

The CHAIRMAN: You are in that now.

Mr. "Y": That is right. I can shake hands with them now. I do not fear them any more.

I cannot say I was a drug addict, because I never was sick. I refuse to "go along" with that idea, which is the idea on the part of many psychiatrists, the same as doctors with heart disease—

The CHAIRMAN: How many "shots" were you taking, when you quit?

Mr. "Y": Not more than two or three. When I quit, I was just "playing along". The last sentence I received, I believe, was from Magistrate Elmore. I was carrying a capsule of heroin to a gentleman who was sick in bed. I did not give that as an excuse, because they would not have believed it. Secondly, if I had made that excuse, I would have been automatically convicted on a charge of transporting, which would involve a much more serious penalty, than the one I was going to receive.

At that time, I was just in from the north country, where I was managing quite a large camp, where I carried sometimes \$25,000 of the firm's money in my pocket. I never stole a cent from anybody who trusted me. I admit I stole to get drugs, and anybody who says he has not, is a stranger to the truth, because, if you are using drugs and get sick, there is not very much you will not do. You will lie to your best friends; you will accomplish your objective some way.

I agree with Mr. Mathews up to a certain point, as to the number he has dealt with, but there are not many drug addicts who will go in for hard work, and so I was in the minority there.

Senator LEGER: What is the greatest amount you have taken in a day?

Mr. "Y": Twelve grains of pure heroin in a day. Buying from a peddler, that would be a matter of 36 capsules, but I was very fortunate for a long time here in Toronto in that I did not have to go near a peddler. I had a doctor. I paid my drug bills like my grocery bills every Friday.

Senator HOWDEN: If you were overtaken by the so-called sickness from opium or morphine; if you had work to do, and were given a "shot", could you do it?

Mr. "Y": That is correct. Some of my best work was done when I was still using drugs. I have something to say on that, but I trust I am not boring you.

The CHAIRMAN: No go right ahead.

Mr. "Y": I have been classed as being a terrific addict, but it has been building up for over forty years, and I think I will have something for you on that.

Prosecutors are concerned with how they can send addicts to prison more effectively and rapidly. I was glad that Mr. Mathews dwelt on the fact that he was more interested in the topflight men. I think you have received more clear-cut information on drugs from Doctor Stevenson in British Columbia, than any of the others whom I have read.

There is a doctor who is an old friend of mine from London, Ontario. He has been a doctor who never refused to give a man what we will call a "fix" when he was sick, and I do not think he ever took time for it. The doctor was not mercenary. I had a doctor who gave it to me three times a day. I went up in the morning at nine o'clock, and again at two o'clock in the afternoon, and in the evening, and on Fridays I settled my bill, and he only charged me \$3.00 every time, and he kept saying, "I wish you would quit".

On the other hand we have a great many doctors who have built big houses from the profits from drugs.

In regard to the suggestion about clinics and so forth in my estimation I am against clinics which allow patients to carry out the drugs. They will not appeal to the drug addicts; many of them will not appeal to the police; some of them will not appeal to the magistrates.

In this case I think they would be making a backward step if they had clinics, where a man could carry out the drug with him. I am not against clinics, if you get the drugs prescribed for you and used at the clinic.

Many years ago, we had a permit system which functioned under Mr. Cowan, in the Department of Health, but it was abused in this way, that it became the means of a man splitting the "stuff" with another.

The CHAIRMAN: You think it would be dangerous to hand out drugs?

Mr. "Y": Yes. I am speaking not as a drug addict. I am a non-active drug addict. The active addict will say, "Give it to them". If I were using it, I would say that is the solution, but let us not get it cheaply, and take it home and use it.

But if you entertain any thoughts of a clinic, or clinical treatment, I believe you should establish clinics where they will have to go and have it put into them, and that might not be a bad idea, but it is not a solution of the drug traffic.

The Mounted Police, in my time, were very efficient chaps, sometimes a little rough on occasion, but they have to be, and they have a very, very hard time getting the top men. I believe they do a better job here than their opposite number on the United States, because I think our Force of Mounted Policemen—and I say this quite earnestly and sincerely, not because one of them is sitting here—that while they have difficulty in getting the top men, I do not think a "fix" is possible with a Mounted Policeman, and, therefore, they have been better in connection with a traffic where there are millions of dollars involved.

Senator HOWDEN: In other words, you think they are gentlemen?

Mr. "Y": Yes, except when they poke a "billy" down your throat, but that does not happen very often. That is one of the things you have coming to you, when you do something wrong.

I do not believe that the jails are places for the withdrawal treatment. When a drug addict is picked up for having drugs, and is thrown into jail,—and this has happened to me—they will not allow any treatment, with the result that the addict has to go sometimes from thirteen to eighteen days without sleep, and not eating any food, and you have to go into court in that condition, you become the pitiable object they portray you as being.

The CHAIRMAN: They give you what we have heard called the "cold-turkey treatment"?

Mr. "Y": Yes. That creates a certain amount of resentment. A drug addict will lie in his cell, and he will say to himself, "Well, it will not be too long, and when I get out, I will catch up, and I will make sure to have some of the 'stuff' on me when I come back here the next time." I do not think there can be a successful cure without the withdrawal treatment.

Now they can use Methadon. I used it, and forgot all about heroin in a short time. It can be used in that respect.

Senator HOWDEN: It would never cure you?

Mr. "Y": No, but it puts you back into shape, where you can cure yourself by becoming active, and doing a certain amount of work. I do not think any other drug will cure the effect of another drug.

Mr. LIEFF: You were going to say something about having occasion to get off the drug. What was it you wanted to say?

Mr. "Y": There were two statements; one from Chief Mulligan, as to the one that is most available, and that is the Mexican heroin, and that was available during the war, that is, the brown heroin which came in from Mexico, and was coming in because the pure refined "stuff" from European countries was not "hitting too good". This was brought in for the addicts, and when there is money, the addicts will get the drugs, and wherever you find money, you will find addicts.

Once the "white stuff" started coming in again, the traffic soon started flowing from the east to the west again.

Drug addiction, as you have no doubt been told, is associated somewhat with the climate, and then, possibly, the police administration is not just what it should be. They do not have the same problem here now.

I know of one very prominent drug peddler who told me the other day—he said, "I do not know what I am going to do to make an honest dollar; I am only selling 10 or 12 caps, a day, where I formerly sold 300 to 400".

The CHAIRMAN: Do you think he will go to Vancouver?

Mr. "Y": He was thinking of it then.

Now, gentlemen, society is adopting a different point of view toward addiction, than it formerly did. I do not think we are now considered as "untouchables". People are becoming more and more enlightened, and the Press is becoming very tolerant in its attitude, and I think now the matter is being looked into. I do not say there is no one whom I know, who cannot be brought back into society. But sending a man to jail time after time is bad policy economically, and for their own morale.

In jails—and I say this without fear of successful contradiction—any place in which I have been—which includes Jackson, Michigan, and a few more places I do not need to mention—I have found the drug addict once he is away from drugs and becomes normal again, is one of the top-flight men in any institution. You will find them holding better jobs, and being better inmates than any other type of individual, although we have been blamed for starting riots. I was blamed for starting one not too many years ago. As a matter of fact, we expected the riot, not that we felt we would get better conditions, but we just wanted to wreck the place.

The drug addict is a very clean man. He washes a great deal, and you will find them living a good life. When you come out of prison, if they have to go to some "flop house", they do not like it, so they are prone to go out and make money so they can live a little better.

After-care is the biggest thing. I was very, very fortunate, as I say. I was only two feet away from going back to my old haunts, where I would have been welcomed, and where there would have been two or three capsules provided for me. I was not too far away from that, when this man whom I have mentioned, stepped in, and saw that I got work.

I may lose my work. I am not too far away from losing it right now. In regard to the people who provide the work at the present time, there is quite a divergence of opinion between me and them. My problem will arise again. If I am strong enough, I will get another job. I am one of those at an age where I shall not get another job too easily. There are, however, drug addicts who are constantly looking around for something to steal, and some merchant will suffer before five o'clock today, but if the addict can pay \$6.00 for a little more heroin, he thinks that is "something".

I would like to see the Dominion Government consider the whole situation. I cannot see how the provinces can administer any clinics, or anything else, with the Dominion having control of the legal side of it.

I would like to see probation for the first-time drug addicts, which is something they cannot get now. The law reads if you plead guilty or are convicted, you have to go to jail. I believe I am correct there, Mr. Carson.

I do not see any reason when a person, either male or female, has succumbed to temptation and uses drugs, and is discovered for the first time, why they cannot be treated the same as someone who assaults a little girl, but, because it is the first time, he receives probation. I cannot see why the drug addict cannot have the first chance. I believe in one chance for any man or woman, as the case may be.

I took the trouble to go down to Lexington not too long ago to look it over. It is a very lovely place. Mr. Martin was down there. But I do not think it is anything except that it carries the big names. It is filled with radio performers and band leaders, and I think if some plan of hospitalization set-up in a nearby point, but out in the country, where drug addicts could go voluntarily if they wished to be cured, it would be a good thing. They should be registered. But let them go off the streets into a government-maintained institution voluntarily if they feel they want to be cured. Then give them the cure, and make them work. You will find that many of them will come to like work. So you can instil the feel of a hammer in a man's hand, and the feeling that he is doing something constructive, but just being in for six months, does not make it possible for a man to return to society. But give him the opportunity and the means for a cure and he will become just as good a citizen as anybody else.

Senator HOWDEN: You spoke of the use of Methadon. How much did you take?

Mr. "Y": I do not know. It was given to me by the doctor, and he never went into the problem. In fact, I did not know he had given me Methadon. I thought I was still getting a small portion of heroin. When he told me after it was all over what it was, I was astonished, but I did not have the reaction.

Senator HOWDEN: You got relief?

Mr. "Y": Yes.

Senator HORNER: You said you were sick for seventeen or eighteen days. All the information we have is that five days is about the limit.

Mr. "Y": I will tell you, sir, that when I was using drugs, the drugs were purer than they are using now. They did not stay sick as long, as with the adulterated "stuff", although sometimes they died quicker.

Well, Mr. Chairman and Senators, I think I have bored you too long now, but I just want to toss a couple of orchids at you. People have called this Committee, "a bunch of tired old men". In my opinion, by and large, this Committee is vastly better than any Committee we have been privileged to have in Canada heretofore. You have the power; you are the upper Statesmen, bearing down on this matter.

We often have committees formed to do this and that. We have one here in Toronto, and yet the Conservative Government has not taken one recom-

mendation of "Bill" Stewart's Committee and enforced it, and yet Farquhar Oliver, the Leader of the Liberal Party, and Mr. Grummett, of the C.C.F., endorsed the Committee's Report, and said, "We have done something", but it was just thrown into the waste basket in Queen's Park, as far as my knowledge goes.

I thank you for your courtesy, and I hope I have done some good.
—Mr. "Y" retired.

Mr. LIEFF: Doctor Stevenson says he never practised in London, and does not know this gentleman.

The CHAIRMAN: I think that concludes our deliberations. To those of you who have come, may I say that we appreciate it very much; and to Mrs. "X" and Mr. "Y", we wish you every success, and the hope that you will keep up the good work you have started. We will adjourn now.

—Whereupon the Committee adjourned at 4.10 o'clock p.m., to reconvene on Wednesday, May 25, 1955, at 10.30 o'clock, a.m., in the city of Ottawa.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

Ottawa, Wednesday, May 25, 1955.

EVIDENCE

The Special Committee on the narcotic drug traffic met this day at 10.30 a.m.
Senator REID in the Chair.

The CHAIRMAN: Gentlemen, we have a very important witness before us today, Dr. Harris Isbell from Lexington, Kentucky, whom I should now like to introduce to the committee.

Mr. LIEFF: With your permission, Mr. Chairman, may I say for the record that Dr. Isbell is the Director of the National Institute of Mental Health, Addiction Research Centre of the Public Health Service Centre, Lexington. He has been in the Public Health Service for some twenty years, and for the past eleven years has held his present position.

Dr. Isbell, perhaps you would tell the committee something about Lexington, your institution there and some of the problems you are facing.

Dr. HARRIS ISBELL: Mr. Chairman, Mr. Lieff and Senators, I am very happy to have the opportunity of appearing before this committee. It is another instance of the co-operation between the United States and Canada, which is actually a model for the entire world. As you probably know, there is close cooperation between Canada and the United States, and a free exchange of information between the various governmental bodies in the two countries which are concerned with the drug problem.

I have known Mr. Hossick, head of your narcotic agency in Canada, for a number of years, and I count him among my good friends. I have known Dr. Roberts, head of your mental health branch in the Department of National Health and Welfare, for a good many years, and I admire his work very much. I am acquainted with the work of individuals in your National Research Council, and I can tell you that you have here perhaps the finest research section on the chemical structure and identification of narcotic drugs in the entire world under direction of Dr. Charles Farmilo of the Organic Chemistry Section Department of National Health and Welfare. Therefore, a visit here does not mean only that I am giving you information—I get just as much as I give and I am happy to be here and see your work.

The CHAIRMAN: Thank you, Doctor.

Dr. ISBELL: With respect to the Lexington Hospital, I think it wise to go back a little in the history of the establishment of the institution to give you some concept of it. The hospital was established by Act of Congress in 1929. About two years were required for planning and acquiring the site; work on the building began in 1931, and the hospital was formally opened twenty years ago this week. On Saturday next we are having our twentieth anniversary celebration. The investigation that preceded the establishment of this institution, and our sister institution at Fort Worth, Texas, took place in the early part of the twenties. The addiction situation in the United States at that time was perhaps somewhat different from what it is today. I think when speaking of addiction we have to realize that we are not speaking of a static thing; there is constant change, sometimes slow and sometimes rapid.

In the 1920's the addiction picture in the United States was perhaps rather bad. We had at that time probably 150,000 to 200,000 addicts in the United States. Also at that time what we now call or what you call in Canada a criminal addict was less prominent in the total picture of addiction than he is today in the United States. A greater proportion of the addicts in those days were individuals who became addicted prior to the establishment of the narcotic laws. There were more medical addicts in those days because, as you can remember, medical science had not advanced as far as it has today and our methods of treatment of many diseases were in those days relatively crude. Surgery had not developed to the point where it is now. We had no specific control for many forms of diarrheal diseases prevalent in the southern United States, which accounted for many cases of addiction. So in those days the picture was this, there were criminal addicts but there were also a rather large number of known medical addicts. Now, these individuals were being arrested and convicted for violations of the United States narcotic laws. They were simply sent to the ordinary penitentiaries and put through the penitentiary system. It was felt, however, that because such a proportion of the addicts were not basically criminal, that there should be some separate kind of institution to handle these particular people and this resulted in the establishment of the institutions at Lexington and Fort Worth, Texas.

It is important to remember that these institutions were set up primarily to care for prisoners—individuals sentenced for violations of the United States narcotic laws. This was and still is the primary responsibility of these institutions. Any room that is left over, any facilities that are available after the prisoners are cared for is available to individuals who can apply voluntarily of their own will and come in for treatment on a voluntary basis.

Senator HOWDEN: Doctor, just before you leave that point. You have told us that a great many addicts were medical addicts, that is addicts who had contracted the habit through medical treatment of diarrheal diseases in the southern United States.

Dr. ISBELL: At that time. And for many diseases in addition to diarrheal disease.

Senator HOWDEN: Did you treat them in common with all others?

Dr. ISBELL: They were arrested, convicted under the United States narcotic laws and sent to the penitentiaries like criminal addicts. That was the pattern prior to the establishment of the hospital. When the hospital was opened these people were from then on sent to Lexington and Fort Worth. Of course non-medical addicts are also sent to Lexington and Fort Worth.

Senator KING: Doctor, you mention the term "medical addicts". Are those people who became addicts through medical treatment?

Dr. ISBELL: Yes, as a result of administration of narcotics by the physician for some disease. That is how we are defining a medical addict.

Senator BAIRD: Those are people who would not normally in any other respect be considered a criminal?

Dr. ISBELL: That is right. The criminal addict was not nearly as prominent when the institution was established as he is today. You can therefore see that we have generally two classes of patients in the Lexington Hospital. The first are prisoners who are sent to us by the Federal courts. These prisoners may have been given a sentence,—a sentence that must be served with time off for good behavior or unless they are paroled. A prisoner may also come in on probation under certain conditions; so he may be with us on a probationary basis—probation meaning that when he has obtained a maximum benefit from his hospitalization we can discharge him

to the supervision of a probation officer. A prisoner who is in on a sentence cannot be discharged until his sentence is expired. The other class of patients are voluntary patients. They are there of their own free will and they can and do demand their discharge at any time. The only mechanism available to us to hold these patients beyond their will is what is known as the Kentucky blue grass laws,—that is addict's slang for it. This is a law of the State of Kentucky which makes it a misdemeanour for a person to be an addict, and for that an addict can be given a sentence of a year. The man goes before the court, states that he is an addict, is given a sentence of a year, but the Kentucky authorities probate the sentence on condition that he comes to us.

Senator HOWDEN: The court that he goes before is what kind of a court?

Dr. ISBELL: It is a magistrates court.

Senator HOWDEN: Is the magistrate assisted by a medical man?

Dr. ISBELL: No, ordinarily not. The only evidence that a man is an addict is the man's own statement.

Senator TURGEON: Must he be found in possession of drugs?

Dr. ISBELL: No, it is just his own statement.

Senator HOWDEN: Would you not think that it would be wise to have a person on the bench founded in the knowledge of addiction?

Dr. ISBELL: Well, you see this is a local law, and most of the people who are referred to the courts are referred by us.

Senator HOWDEN: Would you not still think that if that judge has some knowledge of addiction himself he would be very much better informed to deal with these patients.

Dr. ISBELL: Yes, I might say actually that this is a law that we do not particularly like within the hospital. It is, however, the only way we have of obtaining any compulsion over individuals who come in voluntarily, and actually we cannot make a person go down to the court and go before the judge and admit that he is an addict. We can ask him to do so, but we cannot make him do it.

Senator STAMBAUGH: Do you have to take him if he does not go before a judge?

Dr. ISBELL: We do not necessarily have to take him, we only accept him if we have room. Currently we have a waiting list of 500 people for voluntary admission. We have only so much room and can only take in people as it becomes available.

Senator HOWDEN: How many patients can you handle in Lexington?

Dr. ISBELL: The institution ordinarily has a population of between 1,200 to 1,300, and of these people about 150 are not addicts but are psychotics and who are wards of the United States Government for some reason or other, Indians, Aliens, Coast Guardsmen who have become psychotic. We treat these patients because we have a program for the training of young doctors in this specialty and they get their residency training in that hospital. That would leave us with between 1,000 and 1,100 drug addicts in the institution, and of these 20 per cent or roughly 200 are women, the remainder, say around 800 to 900 would be men.

Senator LEGER: How many of them are prisoners?

Dr. ISBELL: About 70 per cent of the individuals in the institution at any time are prisoners, currently. The reason for that is that the prisoners have to remain much longer than do the voluntary patients. We ask a voluntary patient if he is a first admission to remain for four and a half months. Of course he may

not do so, he may leave after a day or two. On the other hand, a prisoner has to remain as long as the judge has set his sentence for unless he is paroled in the meantime. At any one time prisoners constitute about 70 per cent of the population of the hospital. Admissions average around 3,500 yearly. About half of the admissions will be voluntaries and about half will be prisoners.

Senator STAMBAUGH: What happens to those persons that are certified and for whom you do not have room? Where do they go?

Dr. ISBELL: If we do not have room? So far that has not come up. We have always had room for prisoners who were judged to be suitable candidates for our institution.

Senator HOWDEN: Automatically you would take care of the prisoners first?

Dr. ISBELL: Yes, the prisoners first.

Senator HORNER: Those suitable for your institution. And criminals in the higher brackets would go to the common jail?

Dr. ISBELL: They would go to our ordinary penitentiaries. In fact, many addicts or sellers who have long records of participation in narcotic rackets and so on would not be sent to us but just to ordinary penitentiaries. We also can transfer—

Senator BURCHILL: I was just going to suggest that it would be better to let the doctor make his statement as prepared, and then let us ask any questions that occur to us afterwards. To question him now makes for a disjointed presentation, and I do not think it helps the doctor.

Senator HOWDEN: I know it is not fair to the doctor, but we will lose track of these points, and they are very important.

Senator BURCHILL: Make a memo of it.

Dr. ISBELL: I am perfectly willing to try to answer your questions as they occur to you.

The CHAIRMAN: Just be reasonable, then, honourable senators, in your questions.

Dr. ISBELL: I spoke to you about the fact that we have a waiting list for voluntary patients. A man cannot just present himself at our gate and come in; he has to wait till we have room for him. We may admit patients under different conditions. For instance, the first time person, who has never been with us before, is asked to stay at least four and a half months. A chronic relapsing addict with a long record might be taken in just for withdrawal of drugs; if we feel we can do nothing for him we will just take him in for two weeks or thirty days, after which we discharge him again.

The treatment program at Lexington can be divided into a number of distinct phases. These will include withdrawal of drugs, then physical and mental rehabilitation, and finally preparation for discharge and follow-up. The withdrawal of drugs is a very easy thing to do, providing one has proper conditions, namely ability to exclude illicit drugs, drugs other than those prescribed by the physician, from the institutional environment.

Our withdrawal system works very well. Ordinarily we can have the patient off of drugs in less than two weeks—the majority of them, in far less time than that, probably under a week.

Senator HORNER: Do you administer small doses of a drug in withdrawal treatment?

Dr. ISBELL: Yes. Our system of withdrawal of opiates consists in substitution of a synthetic drug—methadone—for whatever drug he may be using—heroin, morphine, demerol, or what have you. We give him methadone orally twice daily, just enough to minimize his illness; we do not try to keep him from getting sick entirely; that is not possible; we just try to smooth out

the violent early hump, so we give him methadone for whatever drug he has been taking, and then we take methadone away by what we call rapid reduction, meaning we get it away from him in two weeks.

Senator HOWDEN: Do you not get nearly as bad an attack when you use methadone as when you use morphine or any other opiate?

Dr. ISBELL: Oh, no. By using methadone—the only advantage is its long length of action. It lasts much longer than does morphine. So therefore methadone lets the addict down easier. You obviate the acute early phase of abstinence. You can pretty well eliminate it, but you cannot eliminate the chronic phase, the aching and insomnia which occurs towards the end. The man just has to go through with that. But the first violent phase of sweating, yawning, vomiting and inability to eat can be very effectively met by this system. We do not find it necessary to use drastic treatment such as electric shock, insulin, and so on. If you would come down to Lexington, and we would hope to have you, you would be surprised at our withdrawal ward. Your conception of a withdrawal ward may be that of people climbing walls and cutting their throats, and so on, but you would find the withdrawal ward a very dull place.

Senator HOWDEN: Methadone does take the place of morphine to a very great extent?

Dr. ISBELL: It will completely, sir. In addition to withdrawal the next step is physical and mental rehabilitation. After he has withdrawn he goes to a convalescent ward where he recuperates for a few days. During this time the laboratory tests, and so on, have been completed. During the first month the man will have a psychiatric examination plus such psychological tests as may be necessary. At the end of his convalescence phase he goes to a staff where all phases of his case are considered, and a treatment plan made for him. Treatment, of course, consists of physical rehabilitation. In the ordinary cases it requires nothing more than good food. The addicts, after they have been off drugs for a few days, get a “chuck” habit. This means that they eat everything they can find and look for more. Ordinarily they will gain around twenty pounds in the first month.

If the addict is a medical addict and has any disease which is causative of his addiction or has any disease which did not cause his addiction, the treatment of that disease is necessary. Therefore the patient would be treated either on an out-patient basis or within our infirmary for whatever condition he may have. He would be treated by medical and surgical means.

One of our big problems concerns individuals who have chronic painful conditions such as phantom limbs and painful amputation stumps. We frequently have recourse to surgery of one kind or another.

Senator LEGER: Are these services given free of charge?

Dr. ISBELL: Oh yes. An addict who can pay is charged I believe \$7.50 per day. However, the number of addicts who have funds appears to be very small. In the institution we would have not more than one or two pay patients at any one time, and in all probability these would be physicians.

Senator KING: What about the volunteer patients?

Dr. ISBELL: Some of them, if they have funds, are required to pay, but those who have funds are very few. So that in effect, the treatment is available free to anyone.

Now, in addition to physical treatment, psychiatric treatment is available. We have a very large psychiatric staff in our institution, about some 15 psychiatrists, including the young residents who are in training in psychiatry. In spite of this large psychiatric staff we, of course, can offer intensive psychiatric treatment only to a small portion of the population. This is not

as bad as it may sound, because actually the number of individuals who are suitable candidates for intensive psychiatric treatment is rather small; however, for the small number of individuals who are judged to be suitable candidates for intensive psychotherapy, this is available. Simple supportive psychotherapy is available to a larger number; group psychotherapy is still available to a larger number. Within the institution we also have what is known as "Narcotics Anonymous." You might call this, perhaps as one way of looking at it, say, self-administered psychotherapy. They were founded within our institution by the Alcoholics Anonymous group at Frankfort, Kentucky, which is some 20 miles away from our institution, and it has operated within the institution ever since. Narcotics Anonymous has also established branches in some of our large cities, notably New York. Other addicts who are in the Narcotics Anonymous program—if there is no Narcotics Anonymous chapter in their area, which is frequently the case—are sent to the Alcoholics Anonymous groups, wherever they may be. The Alcoholics Anonymous groups are willing to accept these addicts who have been in the program, and who apparently are making some progress. Ordinarily, this Narcotics Anonymous group constitutes about 100 men out of our total population of 800 or 900 male addicts.

Now, we lay a great deal of stress on vocational and recreational therapy—in keeping our patients busy. We think that a large proportion of our addicts are immature individuals who have never learned to accept adult responsibilities—they are individuals of very poor work habits, they are individuals who have been brought up under conditions, you might say, of either too harsh discipline or too little discipline. So we feel it is very necessary to train these individuals in some kind of discipline, to teach them good work habits. Furthermore, we also like to feel that we offer vocational training which will enable them to learn a useful trade suitable to their abilities which they can use if they so desire when they leave the institution.

Senator LEGER: Are your addicts mostly delinquent?

Dr. ISBELL: I think you will find that a tremendously variable matter. It would depend on the particular age group you were talking about and on your definition of delinquency. Perhaps the best thing I can tell you about that is that the Public Health Service has had a sociological research project operating in New York, carried out by New York University under a Public Health Service grant. The project, I think, has now been operating about three years, and they have been studying the young addict in the city of New York, and what they have found, with respect to these young addicts, that about something better than 50 per cent had delinquent records prior to getting into difficulty with drugs. That is, I think, perhaps the best answer I could give you. All our patients who are physically able, are given regular work to do. Types of jobs range as very low level jobs like mopping the floor, up to high level jobs such as acting as technician in our X-Ray clinic.

We offer for a proportion of the patients a most intensive vocational training in such occupations as farming, cabinet-making, garment-making, dental technology and medical technology, plumbing, electrical work, painting and so on. In many of these occupations a man can actually become a finished journeyman; that is upon graduation from the course he may be a skilled cabinet-maker.

Senator HOWDEN: And these men usually accept the training willingly, do they not?

Dr. ISBELL: Yes; actually the assignments to these better vocational programs are eagerly sought. Placement in them is governed to a considerable extent by a psychological aptitude test.

Senator LEGER: Is he accepted by the trades?

Dr. ISBELL: I shall have to qualify my answer to that question by saying that we are able to place a number of them in the trades. That will bring me eventually to one of our weaknesses and difficulties which I shall mention in a moment.

In addition to our vocational or work treatment we have what we call recreational treatment. These individuals not only have bad work habits, but bad play habits. We have an organized recreational program which includes organized athletics. Shows are put on by the patients; we have a very large library; we have a hobby shop where patients may work at their hobbies and create things. Our recreational program is very extensive.

May I now say something about cost? The average cost per patient per day in this very large institution runs between \$6 and \$7, or roughly an annual total of \$2½ million yearly.

Senator BAIRD: That is about what the paying patient contributes.

Dr. ISBELL: A little less than what we charge the paying volunteer, but who does not contribute a great deal to our funds, as I said earlier. These costs are not actually as high as they might seem. I have told you that we have about 200 infirmary beds where we have medical addicts on whom we spend large sums of money for treatments of physical diseases. They cost us about \$17.50 per day per infirmary bed. We also have about 150 psychotic patients on whom we spend a great deal of money. But, if we correct the cost for our infirmary beds and our psychotic beds, for the ordinary healthy addict the cost runs about \$3.60 per day. In other words, if we take out all our fancy medical treatment, the cost of the institution is about that of an ordinary penitentiary.

Senator LEGER: Have you any revenue from the work of the patients?

Dr. ISBELL: Yes. The industries, such as the cabinet-making, garment-making and farming, are set up under a revolving fund, which is called a working capital fund. The government made an initial grant of capital to establish these industries. The industries produce things which they sell to a limited market, namely the Federal Government. For instance, our farm products are sold to the institution which in turn pays the farm for the products.

Senator HORNER: What size farm have you in connection with the institution?

Dr. ISBELL: There are some 1,100 acres, with the chief emphasis being placed on dairy farming. We produce all the milk that the institution can use; we produce about half the beef, all the pork, and about 25 per cent of the vegetables required.

Senator HOWDEN: You are doing pretty well at that.

Dr. ISBELL: This farm produces things, and, as I say, theoretically is paid for them by the institution; in that way the farm capital fund revolves. The furniture factory makes very fine furniture on order from other federal institutions. It has been working for the last several years on a large contract from the clinical centre of the National Institute of Health, making furniture for the very large hospital at Bethesda. In that way these industries maintain themselves; however, the accounts are merely bookkeeping transactions.

Prior to discharge from our institution, the patient is interviewed by the social service department, which department assists him in making his plans, aids him in finding a job, if one can be found for him, contacts the social agencies in the community to which the patient goes, and puts him in touch with that agency which may be able to help him following his discharge. When the patient leaves us he becomes the responsibility of the State or local community to which he goes, and he is out of our hands.

In our particular system I think we have two main weaknesses: First, the lack of any way of committing voluntary patients who are not prisoners. We have had legislation in Congress for a number of years which would permit us to honour a State commitment. By that I mean a State court could meet, declare an addict mentally incompetent and he would be admitted to our institution. If he demanded his discharge when he was under commitment, we would say "no, you can't go," and we would not release him until he was ready for discharge. At the present time we do not have legislation that permits us to do that.

Senator HODGES: Did you say you had this legislation previously?

Dr. ISBELL: Legislation such as that has been before our Congress for a number of years and has never got to the floor of the house. Primarily, the reason is that Congress has been so busy with many other things that this small detail which might help us so much, has not been dealt with. It leaves this gap in our system under which we are unable to hold voluntary patients other than through the medium of the Kentucky Blue Grass Law which we do not like because, among other things, it is a criminal law.

The other weakness we suffer from is the lack of follow-up treatment. A man may come to us and stay for four and a half months, and a lot of money is spent on him; he then goes back to his local community and leaves our jurisdiction. There are of course a number of reasons why we cannot offer more follow-up treatment than we do. First, the geographic area is very large; the institution in Lexington takes addicts from all States east of the Mississippi River, with the exception of the city of New Orleans, from which city the addicts go to the institution at Fort Worth. Our addicts are of course concentrated in the cities of New York and Chicago and when they return to their home communities it is then a question of jurisdiction; it is hardly appropriate under our system for us to go into those cities and set up agencies to aid the addict. They might not even be desirable. The problem is that the agencies within these communities are already heavily burdened with many other problems which are just as important as drug addiction: They are burdened with the problems of psychotic individuals, feeble-minded children, crippled children, and the addiction is just one more problem for the already overburdened state agencies.

Senator HODGES: May I ask you what percentage of your patients you regard as cured?

Dr. ISBELL: I am about to come to that point.

I have already spoken about the flaws as they exist currently. The lack of means for commitment, and the lack of facilities for a follow-up. I think they affect the results in two ways. Since we do not have a follow-up on the addict it is difficult for us to know exactly what are our results. These individuals scatter to all parts of the United States, and if they do relapse, they are engaging in an illegal and clandestine practice so if they do relapse they are not too anxious for someone to know it for fear the police might be involved.

Also, a large proportion of addicts are rather nomadic, they move from one part of the country to another, they move from one part of the city to another and are therefore rather difficult to keep up with or to find.

Now with respect to results: A detailed study was made which was completed around 1940 or 1941 covering the first five years of operation of the institution. That study was carried out entirely by mail. Letters were written to patients who were discharged asking a number of questions as to how they were getting along. Also, letters, where we had permission, went to their families as a check. We found first of all that about 15 per cent of the patients

who went through the institution in those days were reliably believed to be abstinent, as evidenced by their own statements and by taking statements from their families, probation officers and so on. About 5 per cent died during the five-year period over which the study was conducted and so were lost to the study. About 40 per cent were known to have relapsed either by virtue of coming back to the institution or by virtue of having been sent to some other institution and we found it out because reports are made to the Federal Bureau of Investigation who in turn inform us. That left us with about 40 per cent who just vanished—we do not know what happened to them, we do not know whether they relapsed to drugs or whether they were getting along all right. In other words, there was a large unknown in all this, so we are not entirely able to evaluate our results.

Recently we have obtained the funds to establish a follow-up unit in New York City. The duty of this follow-up unit is merely to contact and interview these patients, to determine if they are off drugs. The unit has been carrying on a very excellent program. In spite of many difficulties in the beginning, the unit has been operating well for a period of 18 months now and has succeeded in locating practically all of our patients who were discharged in the New York city area.

Senator HOWDEN: With what results?

Dr. ISBELL: We find that breaking it down by admissions of patients who were first admissions to Lexington, this would include all classes, all categories, prisoners and voluntary alike, that after eighteen months 16 per cent are still abstinent from drugs. This is important: Of many second admissions patients who have been having a second trial, about 15 per cent—

Senator HOWDEN: That is pretty good.

Dr. ISBELL: —about 15 per cent were abstinent from drugs during this 18 month period and with respect to third admissions 13 per cent have been abstinent from drugs for a period of 18 months. Now, what this will mean in relation to the entire number of admissions is difficult to say as yet because first of all the 18 month period is too short. We hope to be able to follow these individuals up over a period of 5 years. Secondly, we say that 15 per cent of second admissions are off drugs after their second trial, but that has to be corrected for the number of second admissions who come back to us, some come back to us, they might have been in jail or something like that happened to them, so a number of corrections will have to be made before you can get what you might call a total "cure" rate. It looks as if in time and over a five-year period the total cure rate with respect to all admissions to the institution from the City of New York will be perhaps as much as 25 per cent, certainly not lower than 15 per cent.

Senator HODGES: Is there any average period between first, second and third admissions? Have you any idea as to how long they go before they come back?

Dr. ISBELL: I do not have that information off-hand. It would, however, be advantageous to have that.

Senator HODGES: That is why I wonder if the 18 months might be a normal period for them before they go back again.

Dr. ISBELL: No, this 16 per cent who are supposed to be still off drugs have been out for 18 months.

Senator HODGES: But some of them have been admitted one, two and three times, and I was wondering what the average time was between admissions.

Dr. ISBELL: We will have to correct for that. I think there is evidence here that there is salvage, even after two and three admissions. In fact the

officer currently in charge of the hospital feels that it is often not too bad for a man to fall one time, that he may need one failure to be convinced that he needs help.

Senator HOWDEN: I would like to ask you a medical question doctor. Is methadone a purely synthetic drug?

Dr. ISBELL: Yes. Chemically it does not resemble morphine. Pharmacologically it might as well be morphine, it has the same effect.

Senator HUGESSEN: Would it be fair to say from the figures that you have quoted that very much the larger proportion of these addicts revert?

Dr. ISBELL: Yes, I think that is fair. That has, however, to be interpreted in the light of the weaknesses of our follow-up system.

Senator KING: Do these people once discharged go on and buy these synthetic drugs?

Dr. ISBELL: No, actually there is very little traffic in the synthetic drugs in the United States. The chief drug of addiction there is heroin.

Dr. HOWDEN: They would buy opiates before they would buy methadone?

Dr. ISBELL: I think they would buy methadone if it were readily available, but so far all methadone is legally produced and the only amount that gets into the illicit market are small amounts acquired by theft or by forging a prescription, so there is not much on the illicit market. It is very satisfactory to addicts, and I am quite sure if it were in the market they would use it.

Senator GERSHAW: How is alcoholism related to the history of these addicts?

Dr. ISBELL: There is a relationship between alcoholism and addiction. At the time the institution was established almost 60 per cent of the patients, of the addicts had been alcoholics who began their addiction because they received an opiate when they were in a hangover, shaky. This however, has become less prominent as the years have gone by. The chances are now that instead of 60 per cent there is only about 25 to 40 per cent of our patients who took to opiates as the result of being alcoholics in the beginning.

Senator TURGEON: What has brought about that change do you know?

Dr. ISBELL: I think it is a matter of better medical practice, increase in education of our doctors, increase in a number of things that we can do for alcoholics and awareness that the giving of opiates to alcoholics is likely to lead to something that is worse than alcoholism. I would think that there are extremely few physicians now who would use an opiate to relieve nervousness and so on in an individual who had been on an alcoholic debauch.

Senator HOWDEN: There is no antidote for methadone.

Dr. ISBELL: You mean for poisoning with methadone?

Senator HOWDEN: No, to take a man off the drug.

Dr. ISBELL: There is no antidote for it.

Senator HOWDEN: There is no substitute?

Dr. ISBELL: Yes, you can substitute methadone for morphine. You can substitute methadone for heroin, or heroin for methadone.

Senator HOWDEN: But that gets you nowhere?

Dr. ISBELL: No. You are in the same spot.

Senator BURCHILL: That figure of 40 per cent that you lose sight of, would you care to say just how many that would represent in numbers?

Dr. ISBELL: Well, some 20,000 individuals have gone through our institution in twenty years' time—it may be now approaching 30,000—so we will

say that 40 per cent of them have more or less disappeared from sight, which would give you a figure of 8,000.

Senator HORNER: The best you can do is hope that a number of these remain cured?

Dr. ISBELL: Yes, but we cannot say; they just disappear; we don't know what happens to them; largely they are unknown.

Senator HOWDEN: You would likely know if they had gone back to a drug?

Dr. ISBELL: It is a hard thing to say, because, among other things, one occasionally runs into an old patient who claims to have been actively addicted for a number of years without protection, so that some of these might fall into that category, but not too many, I believe.

I am sometimes asked if addicts are ever cured. Yes, some addicts are cured, in that they no longer use opiate drugs. I think their philosophy about opiate addiction is similar to that for alcoholism. We have addicts who are taking drugs and we have addicts who are not taking drugs, just as we have alcoholics who are drinking and alcoholics who do not drink. Their philosophy is that "once an addict, you are always an addict", but there are some addicts at least who are abstinent. I personally know at least a hundred. That is, I have corresponded with some of them, some I have seen on occasions, so I am quite certain that they have been without drugs for quite a long time. But the people I know who have been abstinent—and I am not speaking statistically, but of individuals—those who have been off drugs, are getting along all right, and leading some kind of a useful and productive life. I can recall a man from the south who was essentially an alcoholic, and got into drugs by that route. He was in our institution three times, I think, and he was not really a criminal addict, but he had broken the drug laws in that he had stolen to support his habit. The man was, I thought, rather unstable emotionally, and it seemed to me that his outlook was bad: I expected to see him back. He acted as my clerk, and he was an excellent clerk. After he left I did not fill the job of clerk for some time, expecting he would come back and I would again have the best clerk in the institution. That was eight years ago, and the man is not back yet. I get about one letter from him each year. He is getting on all right. He did tell me that he went out and tried to get heroin, but he was too "Scotch" to pay the prices that they charged.

The CHAIRMAN: That is something of a deterrent!

Dr. ISBELL: Yes. The man is now working as an accountant in one of the southern cities. He is getting along all right; he is supporting his family. I can recall another man—going all the way back to 1935—again, an individual from a southern city known for its high crime rate. This individual came from a good family who owned a fine business in this particular city. His family were extremely interested in him. Essentially you may say that he was a "good-time Charley" who had gotten to running around, going to horse races, betting on horse races, and so coming in contact with addicts around the race tracks and getting into the addiction that way. He served one sentence in the penitentiary at Leavenworth, and it was completed in Lexington. This man was regarded by us as an individual with a very dubious outlook. He returned to his native city; he has never lapsed to drugs; and today he is operating a business and is a successful and respected citizen of that particular city—which, by the way, used to be one of the worst addiction centres. But this man managed to make it in spite of the fact that he went right back to the same milieu. He had good assets: a good family, a place to go, and a business, and so on.

Senator HOWDEN: Would you say that the hang-over from opium and the hang-over from alcohol differ only in a matter of degree?

Dr. ISBELL: No, sir; they differ in the symptoms. The symptom picture of a hang-over from alcohol is quite different from the symptom picture of the withdrawal of opiates. The mechanisms that underly the two are, I think, different. We are dealing with essentially different drugs and with different abstinence pictures. The only thing that I know that will produce symptoms of abstinence from opium or an equivalent drug is an opiate, either natural or synthetic. Alcohol will not do it. Conversely, opium will not relieve the symptoms of abstinence from alcohol.

Senator LEGER: Have you the percentage of addicts who, because they were sick, were given drugs, and became addicts?

Dr. ISBELL: In our particular population medical addicts—individuals who became addicts as a result of the administration of a drug for some illness—constitute less than 5 per cent of our admissions.

As I told you, the addiction picture changes. In the United States, over a long term, we have had a decline in the number of addicts,—a steady decline over the years, through the passage of the law: they dropped from one hundred and fifty to two hundred thousand, to around sixty thousand at the present time. This drop, of course, has not been smooth; there have been humps in it. There was a hump in the early twenties; there was another hump, which is still under way, which followed the first world war. We used to see a lot of drugs coming through the port of New Orleans and being distributed out of the port of New Orleans up the east coast into New York. It was distributed from New Orleans to the east and from New Orleans to the middle west. We used to have a great port of entry of narcotics in Kansas City. In the past our addiction problem was largely centered in our white population. Since the end of the second World War the main port of entry of narcotics instead of being New Orleans seems to have become the city of New York. The addiction, instead of now being a problem in our white population in the United States, is now predominantly a problem among our negro population in our large cities. We have seen these changes in our time.

Senator HODGES: Have you any explanation for that?

Dr. ISBELL: I can only give you a hypothesis.

Senator LEGER: Are there many addicts among the soldiers who have returned from Korea and Japan?

Dr. ISBELL: We have not seen many soldiers from Korea or Japan at Lexington. It may be that this is something difficult to get information on. It may be that the army is taking care of these people itself. And they are not getting to us, but we have seen relatively few individuals from Korea or Japan in our population. Perhaps as years go by they will come. I do not know. There is always a lag, you know.

The CHAIRMAN: You were going to mention something about the negroes and whites before you were interrupted.

Dr. ISBELL: I can only give you a hypothesis, but addiction always seems to flourish where one has had economic conditions. It always occurs to the greatest extent in the economically depressed slum areas of the largest cities. During the war the migration of our negro population from the southern states to the north was tremendously accelerated because they could easily get work during that time. The migration was markedly accelerated and the negroes moved into the poor areas of the cities. These areas were vacated by the white population which was fighting its way up and moving out to better areas. The negroes filled up those slum areas, and that is the place where addiction always

flourishes so that when the problem came back after the close of the war the smuggling rings started operating in our negro population.

Senator HOWDEN: Is the negro as susceptible as the Indian?

Dr. ISBELL: The Indian?

Senator HOWDEN: Yes, to drugs of all kinds. It is well known, for instance, that the North American Indian is famously susceptible to alcohol.

Dr. ISBELL: Do you mean by susceptibility that he gets more effect with the same dose than a white person?

Senator HOWDEN: He goes after it harder.

Dr. ISBELL: I am not too certain I could make such a statement and defend it scientifically.

Senator HOWDEN: I have had experiences with cow punchers and Indians in Alberta. The Indians haunted our tents because cow punchers usually have a bottle hidden under their bed rolls. That becomes known to the Indians. We had a difficult time getting rid of them and we would have had double difficulty had we ever given them a drink. I was just wondering about the negro in this respect.

Dr. ISBELL: I have no information on that. I could not say that that was true. My personal feeling is rather than any special susceptibility to drugs in the negro race it is more a matter of social conditions that have shifted the addiction problem to our negro population.

Senator STAMBAUGH: I find I have to leave but I have a question I would like to ask Dr. Isbell. Doctor, you said that your results with regard to volunteer patients have not been very good because the patients could leave whenever they wanted to. Could they not sign a document legally committing themselves in some way?

Dr. ISBELL: No, it is not constitutional under United States law. We tried that when we first opened and we soon had to turn them loose. The first case that went to court we lost.

Before I leave Lexington I would like to speak of research. The law that established the institution also provided that we could carry on our research, treatment and cure of drug addiction. I am speaking of this because it is my own interest and it is what I do.

I should like to tell you that I do not run this hospital at Lexington. It is run by a man by the name of Lowry. However, I am in charge of the research end. In our research unit, which is a relatively small part of the hospital, we carry on two general lines of work. First we do what I like to regard as basic work: psychology, psychiatry, biochemistry, and physiology studies both animal and human in an effort to determine factors underlying addiction and the effect of drugs. We make use in this work of a wide variety of techniques. We use psychological techniques, physiological techniques, and biological techniques. Ordinarily the unit works as a team on specific problems of their own choosing.

In addition to this basic research, which of course I think offers us the greatest hope that we will some day be able to handle this problem in a better way, we carry on what I think is technological work.

This work is carried on essentially for the protection of the public not only in the United States but the world in general. This kind of work consists in the testing of new drugs as they are developed for their addictive properties. I think the committee is already aware of the fact that the chemists have now synthesized a number of families of drugs that have morphine-like properties. What we hope to do with our Technological Addiction Liability Assessment Program is to prevent introduction of these drugs into uncontrolled sale. We regard this as rather important because of some things that have happened in the past. It may amaze you to learn that heroin was introduced as a cure

for narcotic addiction back in the eighties, and it may also amaze you to learn that dilaudid was considered as a non-addicting drug and not covered by the laws in the twenties and was sold in drug stores. The addicts got a lot of this until the drug was brought under the law.

Senator HOWDEN: Is that a barbiturate?

Dr. ISBELL: No, it is chemically dihydromorphinone. Its effect is much more morphine-like than barbiturate-like. Similar to morphine, it is addicting. Demerol was the first of the true synthetics and it was on the market without any control.

At the present time the situation has gotten so complex that we now have five chemical families of drugs with morphine-like effect. All of these are effective pain relieving drugs and all are addicting.

1. Morphine
Dilaudid (Dihydromorphinone)
Heroin
Codeine
2. Methadone
3. Demerol (Pethidine, Meperidine, Polantin)
4. Morphinans (Dromoran)
5. Dithienylbutenes.

There is another group whose fate at the present is unknown. It is called Azacycloheptanes.

You can see from the pharmacological point of view that everything is becoming quite complex. The chemists now have so many more chances of making new drugs. Instead of having one type they have five types, and the drug houses like to get these drugs, of course, and sell them and get part of the morphine market. The testing of these drugs furnishes a means of obtaining information about the drugs' addictive properties before they are released to the market. The drugs are referred to us from two sources; first, from the Drug Addiction Committee of the National Research Council, United States; and, secondly, from the Section on Addiction Producing Drugs of the World Health Organization. We carry out the tests, determine their addiction liability and report back to the National Research Council, who, in turn, through their secretary will make the proper report through the proper channels to the World Health Organization.

Senator HUGESSEN: How do you determine whether a new drug is addictive? Do you take some unfortunate individual and administer it to him?

Dr. ISBELL: We have a number of methods of testing for additional liability. Animal methods are used, both at Lexington and at the University of Michigan. At the University of Michigan these drugs are given to monkeys in an effort to determine whether the monkey will become dependent and develop a withdrawal illness. The drug N-Allylnormorphine is used as an antidote to morphine. If, when that antidote is administered, the monkey becomes ill we know that there is an additional liability. This gives one a pretty good way of testing some drugs on monkeys. We make use of the same kind of procedure except that we use dogs at Lexington. However, a drug that does not produce addiction in dogs and monkeys has to be tested in man, because the species differences in this class of drugs are very great. As an example, I might say it is very easy to addict a man to demerol; it is absolutely impossible to addict a dog, and very difficult to addict a monkey. In the case of methadone it is easy to addict a dog, harder to addict a man and very difficult to addict a monkey. So that in many instances we have to go to man for the final answer, and the methods we make use of most frequently consist in determining whether or not the drug will prevent or will relieve the withdrawal illness.

Senator LEGER: How do you test a man?

Dr. ISBELL: It is not problem. You can take men prisoners who come in, and who still have an active habit—we take these individuals, who volunteer for this kind of experiment; we stabilize them and give them a repeated fixed dose of morphine. We then begin a new drug in very small doses, finally stop the morphine, and continue the new drug. We then take away the new drug and see what happens. If the new drug suppresses the appearance of abstinence for morphine, and if abstinence appears after withdrawal of the new drug it is regarded as having addiction liability. This is the most usual method. Very occasionally we may have readdict prisoner volunteers who are off drugs. That method is seldom used, because it is a very, very expensive method. Since these individuals are prisoners there is always plenty of time to complete the drug test, withdraw them and put them through the usual treatment procedure. So we do that.

I hope I have given you some outline of our research at Lexington. Time permits me to say no more.

Senator HOWDEN: Do you systematically switch over from morphine to methadone in all your cases?

Dr. ISBELL: Yes; in our routine treatment the individual is given methadone.

Senator HODGES: As the result of your long experience in Lexington are you prepared to subscribe to the theory we have had placed before us, that all drug addicts should be entirely segregated?

Dr. ISBELL: You mean, take the addicts and put them on some kind of an island or mountain top?

Senator HODGES: No, not necessarily, but in an institution or hospital.

Dr. ISBELL: And keep them there forever?

Senator HODGES: I am asking your point of view, doctor.

Dr. ISBELL: Well, it seems to me, first of all, this is an admission of defeat—it says that we cannot do anything for these people, and I believe there is sufficient evidence to indicate that for a percentage of them, at least, something can be done. Further, if our treatment were what we might regard as adequate, our results might be even better. So I would hate to admit defeat in that way and to say that all we can do is put these people away. Again, if you consider Canada, you have in this country some 3,000 addicts, I believe, according to the testimony I have read—about 2,000 criminal addicts, about 400 arrests a year; you arrest 400 this year, put them in an institution, and arrest 400 next year, and so on, and soon you would have the entire 2,000 in this institution; it would make it a very large institution; and I can assure you larger than Lexington, and it would be very expensive no matter where you put them, and whatever you did about it you would still need a large security force to prevent drugs coming into the institution and to prevent the individuals, who naturally would not wish to stay there for so long a period of time, from escaping. So you would just have a kind of Devil's Isle, I think.

Senator HOWDEN: The island idea was originated in this committee, that is, the idea of breaking connection with the traffic.

Dr. ISBELL: Yes, and I am not sure it would do that. I gather from reading the previous testimony that if you got all the addicts and tucked them away the market would disappear. I am not so sure it would. Of course, I cannot say that it would not.

Senator KING: Would it not have a psychological effect on the public, though, if the criminal addicts were confined for life in some institution?

Dr. ISBELL: I am not sure that it would have the effect that you desire. You know, an individual, a young man starting out on his career of addiction never feels that he is going to be an addict—that he is going to be hooked. He always has the feeling that he is stronger than the drug. He says to himself, “I will take a few shots, have a good time, but I won’t get hooked.” But he does get hooked, and, you know, no matter what penalty you set up there are always people who will even risk death to get what they feel they must have. I am not sure that it would have this deterrent effect, and I am not at all sure it would abolish the illicit market. It would certainly be a very expensive operation, and as I say, it is an admission of defeat, it says we can do nothing for these people, that they have no chance, and I believe that is not true.

The CHAIRMAN: Do you feel that deep down in their hearts these people really want to be cured?

Dr. ISBELL: Yes, they do. Now, you have to remember that such addicts have, so to speak, two feelings, or to use a psychiatric terms, ambivalence; they would like to be cured but would like to have their drugs at the same time. Many of us are ambivalent about many things in life, the addict is ambivalent about drugs, and he would like to be cured and like to have his drugs. We have to try to strengthen his desire to be cured.

Senator HODGES: Would you be in favour of providing drugs for these addicts?

Dr. ISBELL: Absolutely not, absolutely not.

Senator HOWDEN: Hear, hear.

Dr. ISBELL: I am convinced that the legal control of drugs has resulted in a marked increase in the number of addicts in the United States—from 50,000 to 60,000, over the course of the years. I do not know what has occurred in Canada—perhaps the same thing. As far as the United States is concerned, I am convinced that legal control of drugs has mitigated the addiction problem in the United States. I would hate to think what the addiction problem in the United States would be today if it had not been for legal control of drugs. You either have legal control or you do not have it; I cannot see any middle course.

Suppose we did try to set up a narcotic “bar”, and run this service. Certainly, we are not going to give the addicts the drugs to take themselves, for they might sell them. We have to have the drugs and administer them, which means that one of these narcotic bar rooms will have to be set up at spots around the large cities in Canada; they would have to be manned twenty-four hours a day, seven days a week. The addict requires drugs four or five times a day, otherwise he will become ill. Therefore, he is going to spend all of his time waiting in the so-called clinic line-up to get his drugs. In my opinion, it is an utterly unworkable thing.

Many addicts will tell you that if they had just enough drugs to maintain themselves comfortably and would not become ill, that they would work and become productive citizens and all that sort of thing. Such a statement is perhaps true of a minor proportion of addicts. People in this business tell me they have known addicts who have held their dosage level for a period of years and have worked. That, however, is the exception. The majority of addicts don’t want to be normal; they want to be what they call “high”—they want to be “loaded”. If you provide them with drugs by this single-shot mechanism at five trips a day, that is just enough to keep the addict going and he will go out and get more so that he can get high.

Senator HOWDEN: He wants a bigger load.

Dr. ISBELL: Yes; it is not enough for him to be normal. If it is decided that it is physically impossible to have these people wander in four or five times a day, then you might ask, “Why can’t we give them drugs for self

administration?" I think the answer is obvious: Not only would the addict fail to maintain his dosage, but his tolerance tendency would go up; indeed, the only limit to tolerance is the amount of skin available to inject, and the time required to take so many injections. Not only would the addict raise his dosage, but he would call for a variety of drugs, and all sorts of abuses would grow up. They would get their maintained doses from the so-called narcotic bars, and then they would go out and buy more on the illicit market. Such systems have been set up in various parts of the world—I believe in some of the Asiatic countries—and it has been found always that the illicit traffic exceeds the legal traffic.

The CHAIRMAN: Dr. Isbell, do you find much drug traffic around Lexington?

Dr. ISBELL: There is very little. This is due partly to location: Lexington is a small middle-class city which is off the main routes of travel in the United States, and the institution is located seven miles out of Lexington; it is situated in the middle of a farm, surrounded by a wire fence. Actually, we are protected by geography and distance from trafficking; there is no great centre of drug traffic around Lexington. Furthermore, the Bureau of Narcotics maintains an agent in Lexington. So that a "pusher" in Lexington is promptly chased; I believe it is rather a hot spot for a drug peddler. We have no great problem there.

Mr. LIEFF: Doctor, would you like to say a word about the British system?

Dr. ISBELL: I think you know about as much about the British system as I do. I only know what I read, and I read everything I can find on it.

I must say that I am somewhat confused: Great Britain has a drug law; it has signed all the international treaties and conventions which the United States and Canada have signed; it has an enforcement system. Yet, with all these, it is said they have no drug problem. It is a little hard for me to understand why they have all this machinery and have no problem.

Furthermore, one often hears it said that an addict can be given drugs in Great Britain. We know that is actually not the case. A physician in Great Britain is allowed to give drugs to an addict only under certain very closely specified conditions, which have already been made part of the evidence before this committee, and I do not need to go into them. The outstanding feature is the apparent lack of criminal addiction in England.

In accepting the facts, I merely say that England is not the United States; that social conditions in England are far different from those in the United States. Apparently we have an addict-prone population.

Senator HOWDEN: Anyway, you would not recommend that type of treatment here?

Dr. ISBELL: No.

Senator LEGER: What do you believe is the proper form of punishment for the trafficker or peddler? Do you believe in long terms of imprisonment?

Dr. ISBELL: Yes, I do. The difficulty is in determining who is a trafficker and who is a user. The small petty addict, sometimes referred to as the "boot and shoe" addict in the United States, is almost inevitably at some time in his career a peddler, if only for the reason that he is trying to accommodate his friends who may temporarily be short of drugs. But as I say, it is most difficult to distinguish between a user and a peddler, because they are interchangeable.

The CHAIRMAN: How many types of drug addicts have you in Lexington which use heroin, barbiturates and so on?

Dr. ISBELL: I would say that practically all, or about 80 per cent of them use heroin, which is the major drug of addiction in the United States at the

present time. The remaining 20 per cent are probably addicts from the southern States. In the southeastern United States we have a somewhat different pattern of addiction. In those parts of the States there are a few addicts in each town of any size or in each small city, with no great concentration in any one place; it is a rather diffused problem. These southern addicts do not buy illicit heroin to any extent; they are dependent upon getting prescriptions from doctors by fraud, deception or forgery, and by theft from drug stores. The drugs normally used by these southern addicts are morphine, dilaudid, and the synthetics methadone and demerol.

Senator HODGES: Do you have many who are addicted to the use of marijuana?

Dr. ISBELL: We get very few pure marijuana addicts. I would say there are no more than two or three in the institution at any one time. However practically all heroin addicts from the centres, particularly the negro population, used marijuana before beginning the use of heroin.

Senator HODGES: They sort of graduate from one to the other.

Dr. ISBELL: Yes.

Mr. LIEFF: Doctor, a suggestion was made by one of the witnesses that we ought to develop plans for an experimental rehabilitation centre to be located near Vancouver which, as you know, is the large drug centre in Canada; the size of the institution would be large enough to accommodate say twenty-five people to begin with, preferably voluntary patients. Some persons could be brought from the prison at Oakalla and they need not all be criminal addicts. It was suggested that there be two kinds of program, one for men and one for women, and that certain forms of rehabilitation, even to a brief stay in a general hospital, be undertaken.

Would you care to make any comment on whether that would be a feasible plan, how it might work out and what difficulties if any might be encountered.

Dr. ISBELL: Well, I like the plan, first because you use the word "experimental". I do not think we know all the answers to the treatment of addiction, not by a long way. Therefore, in any program that you would set up, I would suggest that it be made flexible, with provision for trying a variety of treatments. This is a suggestion that I would have no great objection to, provided it is recognized as an experiment and further recognized that you might get into some trouble, especially early in your operation.

Senator HOWDEN: It is only fair to tell you, Doctor, that out of 150 men at the prison, there were perhaps a dozen who testified that they had no wish to stop using heroin; indeed, they felt that any coercion in that respect was an infraction on their liberties as Canadian citizens.

Senator HODGES: Dr. Howden is speaking of the Oakalla farm.

Mr. LIEFF: You were saying that we might encounter some difficulty in the early stages.

Dr. ISBELL: Well, one of the difficulties one might run into is in setting up the necessary drug-free environment within a general hospital setting. It is not an easy matter to keep drugs out of a withdrawal ward, it requires constant vigilance, constant service, it is not an easy thing to do so, and if we attempt this kind of thing we might look forward to having some difficulties in operating this drug-free environment, not forgetting that some scandal would crop up occasionally.

Senator HOWDEN: That certainly would be the case with drugs around to that extent.

Dr. ISBELL: However, if the people, and if there are enough of them to go into this program—are highly selected individuals, individuals with everything in their favour except the fact that they are addicts, it might be a very nice

thing to have this as part of a system for handling the addiction problem. Also, in the second phase of this treatment which I understand is rehabilitation, you might run into some difficulty there. If you have a group of addicts all together—it requires roughly 60 days to get over all the physical effects of a narcotic habit, and during this time, the individual is extremely vulnerable to relapse to drugs until the overall physical effects have disappeared; of course he is always mentally extremely vulnerable to it—some problem might come up in the rehabilitation phase. However, I think an interesting thing to do is to have it regarded as an experimental approach which could be altered or dropped if it did not work out. I think I would like to see it done as an experiment.

Mr. LIEFF: What would you say with respect to the feature of the plan which indicates that the inmates or patients would have to be volunteers. Would that present any difficulty?

Dr. ISBELL: I do not believe it would. I think you would find a sufficient number of people volunteering to operate a small unit such as this. Addicts would like to be rid of their habit and still would like to have the drugs. If you get one at the time when he is trying to get off drugs, well, you have got something.

I can remember one of the most impressive things that ever occurred to me. It happened when I was resident in Lexington in 1935. A young doctor came in there, a very fine chap, with a very fine background, highly trained, in fact he had done post-graduate work at McGill University.

Senator HODGES: He came as a patient?

Doctor ISBELL: As a volunteer patient, yes. I was running the withdrawal ward at the time, so this young man came in and he had a tremendous habit, he was really sick. So I was very anxious to treat him, I wanted to give him some drugs to mitigate his abstinence symptoms but he would not let me do it. He just laid down and kicked it cold, as the boys would say. After he kicked it cold he got up and I offered what an ordinary addict would regard as a very fine job as a clerk, but he would have none of it. On the other hand, he went out on our farm, he went out in the sun, pitched hay, did hard work. He stayed for six months and then he left. I hear from him once a year and he is all right now. Now, there was an individual who was highly motivated to get off. He did, and he is still off it.

Mr. LIEFF: Would you permit me to get back to this cottage plan, Mr. Chairman. Say we have 15 individuals in it. Should we maintain legal control of the people there or let them go and come as they like.

Dr. ISBELL: As an experiment let them go and come as they like, but I am afraid you will run into difficulties. I personally would favour some kind of control, a very flexible kind of control so that individuals could be given freedom very gradually.

Mr. LIEFF: Could we discuss another type of institution, an institution say that would accommodate 150 patients, where there would be total security; a fully controlled institution, where the patients would get medical care, psychiatric and psychological service, educational programs, vocational training, do what has been called constructive work, proper recreation programs—as you have already discussed.

Dr. ISBELL: It looks like a small Lexington.

Mr. LIEFF: A small Lexington, yes, with a proper follow-up system, proper probation, a small Lexington, housing about 150 patients.

Senator BAIRD: That would be rather expensive.

Dr. ISBELL: I personally would be in favour of such an institution but whether, or not such an institution is established of course would depend on many considerations. I think it would depend on the number of addicts you

have in your institutions, and on many other factors in Canada which I am of course not aware of, but I do think in attempting to do something about addiction that we should use a kind of a graded system for the betterment of your so-called criminal addicts. I am not sure that it needs to be an institution of this type but I do believe that the type of care should lay emphasis on rehabilitation with important heavy emphasis on follow-up and the use of community resources to help these people after a hospitalization period. I think for a part of your population it would be a very fine program.

Mr. LIEFF: I wonder if you would deal more extensively, if possible, with some of the problems in regard to placement, follow-up and that sort of thing and whether the social agencies are presently overburdened.

Dr. ISBELL: Yes. Well, a man can go through a period of institutional care and leave with all the best intentions in the world, returning to his community and he finds there is nothing there for him. He cannot get a job, and he has no resources, he has nothing. He goes to the social agencies and finds that they are already tremendously overburdened with many other problems. As I say, they are afraid of addicts, they regard addicts as sex crazed killers, as potential killers and so on, and they are afraid of him and will do nothing for him, and in order to eat that man almost immediately has to drop back into some kind of criminal activity. But the minute he goes into criminal activity he is going to head back for drugs. A person going out after a period of institutionalization—this, I think, applies not only to addicts but to other types of delinquency as well—needs a great deal of help, support, supervision, which is, I think, properly the responsibility of the community; and there should be some means of providing these necessary aids for these people, among other people, when they have finished a period of institutional treatment.

The CHAIRMAN: What has been your experience with the cases drawn to your attention, of a man who has been a long time in crime and takes to drug addiction and finds himself in jail? What happens to that criminal after you cure him of drugs and he is let loose? He may not take drugs, but does he become a new man, a good citizen, and does he cease to burglarize and thieve?

Dr. ISBELL: No. I think a man with a record such as you describe, a long anti-social record of twenty or thirty years, is very likely to go back to the same kind of occupation that he was in before, namely some kind of criminal activity. On the other hand, I think you will find you can take non-addicts who are delinquents or have some kind of criminal activity, but whose records are not so long, and find that a proportion are permanently rehabilitated,—just as is true of addicts.

Senator BURCHILL: Would a large proportion of your people who go out under conditions such as you have described, without any references, have any chance of a job being ready for them when they go out? Would you say that there are quite a number of your people who are in that situation?

Dr. ISBELL: Well, as I say, in the eighteen months' period in which the New York follow-up program has been operating properly, 16 per cent of the individuals have been through that institution once.

The CHAIRMAN: What is the attitude of the employer to that type?

Dr. ISBELL: Ordinarily it is very difficult for these people to get work, if the employer knows that the individual is an addict.

Senator HOWDEN: In brief, if an addict can get a supply of drugs that satisfies him, without being punished too much, he will prefer that to cure?

Dr. ISBELL: I am not sure that he would. I keep saying that these people are ambivalent: they like to be free of that condition; on the other hand they do like the drugs. I think there is no doubt they have both feelings.

Senator HOWDEN: I know, but I think the latter feeling is the stronger.

Dr. ISBELL: I am not sure that it is. I think it is, but it varies from time to time and from person to person.

Senator HOWDEN: We have had some so-called "cures" come before us, and if I know anything about human nature—and I have practised medicine for fifty years—they are not cured.

Dr. ISBELL: It is always a difficult matter to be sure a person is off drugs.

Mr. LIEFF: Have you any idea of the capital cost of Lexington?

Dr. ISBELL: At the time it was built it was about \$5 million. Today it would probably cost three times that much.

The CHAIRMAN: We have been asking you a lot of questions. Are you through with your prepared statement?

Dr. ISBELL: Yes.

Senator BEAUBIEN: In your institution what is the proportion of new addicts that come in?

Dr. ISBELL: Well, that has varied through the years. Of the whole 20,000 individuals that have been through our institution, 60 per cent have only been through one time; the other 40 per cent have been there twice or more—up to some recordholders who have been admitted as many as twenty times.

Senator BEAUBIEN: In that 60 per cent would you find many addicts of the younger generation?

Dr. ISBELL: Yes. In the last five years or ten years, among the group that have only been through one time, a large proportion were young coloured boys who are in the third decade of life—in the early twenties.

Senator HUGESSEN: The majority of them have come to that addiction through previous crimes, eh?

Dr. ISBELL: According to the preliminary work in New York City by the N.Y.U. Department of Sociology, a little better than 50 per cent of these younger addicts have delinquent records prior to addict. All, of course, are delinquent after addiction.

The CHAIRMAN: How young do you have them, and how old do you have them?

Dr. ISBELL: The extremes have been up to over seventy, almost eighty.

Senator HODGES: Are there many who come back? Many repeaters?

Dr. ISBELL: I am not sure about them being first-timers there—the older men. One old machinist who comes back to us again and again is approaching eighty. I keep telling him that the drugs will kill him some day! But there are some individuals around eighty, and the youngest addict I can remember was thirteen—if he were an addict; he undoubtedly had been "chipping" around.

Senator BEAUBIEN: But undoubtedly the high percentage of them would be around twenty to twenty-five?

Dr. ISBELL: Yes. I think the median age of the population at present is about twenty-seven.

Mr. LIEFF: Your institution produces a lot of dairy products and agricultural products and other things?

Dr. ISBELL: Yes.

Mr. LIEFF: To what extent does that help to support the institution?

Dr. ISBELL: It all depends on how you look at it. The hospitals is given money with which to operate, and the hospital pays the farm for the things the farm produces. The farm makes a profit, and that goes back to the treasury. So as I say, it all depends how you look at it. From the point of view

of the individual managing the institution, he does not like that too well, because he still has to pay for the farm products, which uses up part of his money.

Mr. LIEFF: It is far from self-supporting.

Dr. ISBELL: Oh, yes, it is far from self-supporting.

The CHAIRMAN: Does an inmate receiving compulsory treatment get any remuneration?

Dr. ISBELL: No, he does not get paid for working in an industry in our institution, as he would if he worked in an industry in an ordinary penitentiary.

Mr. LIEFF: A suggestion has been made during this investigation that we might pay them proper wages and that their standard of living would depend on how much work they did, how well they worked and that sort of thing. Has that been considered in any of your institutions?

Dr. ISBELL: I think that in the federal penitentiaries, where wages are paid, a man has to produce, otherwise he will be taken out of that job, which is a desirable job; he gets money for it and he also gets time off his sentence for it. In Lexington we do not have money to pay them for their work, but they do get extra time off their sentence for working in these capital-fund industries; so they are rewarded in that way. Also in the industries they have a system in which the individuals go through an intensive training program and all the skills that those industries require. Those individuals who do the best get a promotion and are given more responsibilities and freedom, and so on, than you might say the ordinary journeyman gets. They become the teachers, and to some extent the foremen.

Mr. LIEFF: Do they stand a better chance when they get out?

Dr. ISBELL: That we do not know. We do know the competition to become patient leaders is rather fierce.

Senator BEAUBIEN: When a patient gets out of your institution what does he go out with? Does he go out with anything at all?

Dr. ISBELL: When the patient leaves the institution?

Senator BEAUBIEN: Yes.

Dr. ISBELL: If the patient is a prisoner he would be given a full set of clothing, a suit and an overcoat, if it is wintertime, shoes and a hat, and so on. He gets \$25 gratuity and transportation to his home. Of course, if he is a prisoner he has to report within a specified period to his probation officer. We have no provision for the volunteer patients. We can give them clothing which has been given to us or left to us and which we have repaired, but we cannot give them new clothing. Under certain conditions we can furnish them transportation and a small gratuity, but not as much as the prisoner would get.

Senator STAMBAUGH: Doctor, when you were giving us per-patient day costs were you taking into consideration capital costs?

Dr. ISBELL: The capital costs of the institution, no. I was giving you the amount of money they appropriate to us to operate for a year.

Senator STAMBAUGH: When you are taking that into consideration does it mean you calculate depreciation?

Dr. ISBELL: It does include the cost of maintenance of the building but it does not include depreciation.

Senator STAMBAUGH: But it does include heat, light and repairs and alterations?

Dr. ISBELL: Yes.

Senator HOWDEN: Mr. Chairman, our witness has been before us for nearly two hours and we are now asking him a lot of hypothetical questions here, there and all over. He has given us an outstanding submission, the equal of which I do not think we have had before. However, I think we should have some mercy with the gentleman.

The CHAIRMAN: Senator Baird has not asked many questions and I think he has one to ask now.

Senator BAIRD: I just have one question to ask. What proportion of outsiders come to this place? It is not all run by patients, is it?

Dr. ISBELL: No, we have a large staff. The institution employs something under 500 people. These people come in all categories. We have physicians and nurses and a large number of what are known as work supervisors. The job of the work supervisors is to teach the patient good work habits and also to teach him skills. This is regarded as treatment and not as punishment.

Mr. LIEFF: Your staff ratio is one to two and a half.

Dr. ISBELL: Roughly that.

The CHAIRMAN: Are there any other questions?

Senator LEGER: I should like to ask one question. If the revenue from your farm and plants was given to the institution rather than to the government, do you think it would pay 25 per cent of your maintenance?

Dr. ISBELL: I honestly do not know, sir, but I could find out. A great deal would depend on the current level of activity in such industries as the furniture factory. In recent years we could theoretically make a good showing because the furniture factory has had a million dollar order.

The CHAIRMAN: Dr. Isbell, on behalf of the members of the committee I wish to express our appreciation to you for giving us such a remarkable submission. It has been of great value to us.

Dr. ISBELL: It has certainly been a pleasure to be here.

The committee adjourned to the call of the Chair.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

MONTREAL, P.Q., Friday, May 27, 1955.

EVIDENCE

The Special Committee on the Narcotic Drug Traffic met this day at 11:00 a.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable Senators, may I point out, first of all, that our programme does not seem to be a very heavy nor extensive one today. We might very well finish fairly early.

The first witness is Mr. E. Brakefield-Moore, Acting Officer Commanding of "C" Division, of the Royal Canadian Mounted Police, who I will ask to now come forward.

Edwin Brakefield-Moore, Acting Officer Commanding "C" Division, Royal Canadian Mounted Police, Montreal.

Mr. LIEFF: Mr. Chairman and honourable Senators; Mr. Brakefield-Moore is in charge of "C" Division of the Royal Canadian Mounted Police, in Montreal.

The CHAIRMAN: Will you proceed please, Mr. Brakefield-Moore.

Mr. BRAKEFIELD-MOORE: Mr. Chairman, and honourable Senators; by way of introduction, may I say I am the officer in charge of the Criminal Investigation Branch for "C" Division of the Royal Canadian Mounted Police, in the Province of Quebec. Beside that, I am also Officer Commanding the Division.

The submission which I am about to make to the Committee with regard to the illicit traffic of narcotics in the province of Quebec has been prepared by drawing on the experience of non-commissioned officers and constables of the Royal Canadian Mounted Police engaged in combatting this type of criminality.

Although a few criminal addicts are found in other parts of the province of Quebec, the great majority of addicts lives in Montreal in order to be close to a steady source of supply of drugs. Another very important reason for this concentration is the need to have daily contacts with their criminal associates with whom they discuss almost exclusively the availability, cost and price of drug, as well as ways and means to obtain funds for their daily supply.

As elsewhere in Canada, the criminal addict makes use of heroin almost exclusively. Even the few Oriental addicts to be found in the Montreal district are users of heroin. Opium and morphine, which were the drugs of addiction prior to the second World War, are seldom encountered in this province nowadays. The main reason would appear to be that heroin is considered to be three times as strong as morphine, and thus gives a more lasting satisfaction to the addict. The use of marihuana—or cannabis sativa—is not a problem in this province although isolated seizures are made from time to time from visitors to this country or from Canadians who have contracted the habit while living away from Canada, or by associating with persons addicted to this drug.

It is difficult to give exact figures of criminal addicts in this province due to the fact that these persons often move from one city to another, usually for the reason they are getting too well known to the police. Invariably, these transients proceed to a city where a source of supply is assured and where facilities exist to ply their illegal activities. There is also a small group of addicts who leave Montreal for short periods to engage in work or criminal activities but almost invariably return to this city. The following approximate figures of criminal addicts and peddlers of narcotics in this area as of April 1955 are submitted:

- 100 criminal addicts at liberty;
- 75 persons associated with trafficking or as users of narcotics now in penal institutions;
- 4 traffickers (non-addicts);
- 18 individuals presently before the Courts charged with trafficking;
- 25 new addicts added during the past three years.

Although the policy of the Royal Canadian Mounted Police is to apprehend the traffickers rather than the addict, in this city our Force has found from experience that the majority of addicts is at one time or another engaged in trafficking on behalf of non-addict peddlers. For this reason, both addicts and traffickers have come in for their share of attention. The Montreal city police maintain a drug squad with whom we exchange information on both addicts and peddlers. A number of prosecutions have been the result of joint investigations by members of the Montreal city police and members of this force.

Another very good reason why our force interests itself in addicts and street peddlers is that surveillance and investigation of these people often lead to important traffickers. In a major undercover investigation during 1950-1951 which led to the arrest of seven traffickers operating on a national and international level, our undercover member, acting as a trafficker over a period of twenty months, was able to work his way up from buying a few ounces of heroin from a local "boss" of street traffickers through association with addicts and street peddlers. The result was that at the end of the investigation he was contracting to purchase heroin by the kilogram from the then "kingpin" in the wholesale traffic in Eastern Canada.

The head of this group admitted, when apprehended, that he had, throughout Canada, disposed of many kilograms of heroin obtained from the eastern United States. Our inquiries let us to believe that this particular group had indeed been supplying heroin to traffickers in the Vancouver area, and elsewhere in Canada.

In another major undercover operation in 1949, which lasted eight months, four members of a large distributing ring were apprehended. Investigation showed that the head of this ring had drug connections with international criminals in France, Italy, North Africa, the United States and Mexico. We have every reason to believe this man was in a position to supply amounts up to fifteen kilograms in any one delivery.

This type of investigation is the most effective against distributors of that importance, but is not without danger to the member of the force working undercover. In such a case, the undercover member does not as a rule associate with addicts as they are not trusted by the important traffickers, who make it a point never to come in contact with addicts. The investigator must establish a reputation as a large buyer and supplier of drugs before he can gain the confidence of such large distributors. One false move on the part of our undercover member, or those assigned to keep the necessary observation, can ruin the whole operation. Needless to say that such large

operators are invariably experienced criminals who employ numerous stratagems to test the reliability of our member. Cases have occurred where such operators have had our undercover member kept under continuous observation for long periods in order to discover any flaws in his background and reliability.

Besides these major undercover investigations in this province, we have, on quite a few occasions, apprehended street peddlers and addict peddlers by having a member of the force pose as an addict. This type of operation, although not as dangerous to the undercover man as the previously mentioned cases, cannot be said to be without risk. One thing that has been learned from these undercover investigations at this level is that the street peddlers, although anxious to make a profit, are most wary of dealing with newcomers and will invariably only supply him through a known addict until the newcomer has associated for some time with other known addicts. The best recommendation to a peddler is that the newcomer is indeed engaged in some criminal activity for, invariably, the addict is a criminal before he becomes an addict, and must continue being one to support his habit.

We have been alerted to the possibility of juvenile addiction in this province, and any suggestion or suspicions has always been quickly and thoroughly investigated.

Since the second World War not a single case of juvenile addiction has come to light in the province of Quebec. A boy, age 16 years, who had been a delinquent for some time, was strongly suspected of being addicted to heroin during 1954. Through frequent observation we have reason to believe that if at one time he was addicted, he is no longer making use of drugs.

It is commonly believed that drug traffickers, (non addicts), solicit business by giving free samples in order to create new addicts. Our experience does not bear this out for, as stated previously, the peddler although greedy for money, will not do business with an unknown person for fear that he is connected with the police. The addict is the person who invariably makes a new addict, for misery loves company. Of approximately fifty criminal addicts questioned by our investigators in recent years, all admitted they had first been introduced to the drug habit by an addict with whom they had been associated. With a few exceptions, these people also admitted they were engaged in some form of criminal activity before becoming addicted to drugs. It would seem that as a general rule crime may lead to drug addiction, but it is seldom the reverse.

The average criminal addict does not appear to have a great desire to be cured of his habit despite the misery he lives in. A number of instances have occurred where on being apprehended addicts have expressed the desire to be cured of their addiction. Through enforced abstinence whilst in jail, these individuals have been cured of their addiction, but on being released from custody, even after several years of non-usage, they have immediately sought the company of addicts and started using drugs within hours of their release from jail. The bond between addicts appears to be even more compelling than that between members of a fraternal association.

Despite vigorous action on the part of law enforcement agencies in breaking up rings of traffickers, the traffic continues. It is too lucrative a field for the criminal to vacate. As soon as an important trafficker is lodged in prison, several other criminals are ready to move in and take his place and, in many instances, they are not above using violence against each other to gain this doubtful honour. The addicts, on the other hand, seldom, if ever, resort to violence. "Organized crime" and "addiction" are by no means synonymous; the addict generally sticks to petty crime, while organized crime is loath to trust the addict because of his unreliability.

It would appear that a continuous and vigorous attack on the traffickers is not the answer to the suppression of drug addiction although this course

is absolutely necessary. The answer to the problem would seem to lie in the opposite direction, that is, vigorous action against the addicts. As long as the addict creates a demand and is willing to pay high prices for his drugs, the more important criminal element will supply it much the same as other types of criminal commodities or services are provided, despite police action.

A number of previous witnesses with great experience with this problem have suggested some form of isolation for addicts, and I would like to endorse this plan. I feel that addicts who have been placed in such isolation should only be released on a strict parole system. A condition of their parole should be that they do not live in large cities where they are likely to make contact with old associates. It is seldom that a source of supply for criminal addicts can be found in small communities and these would appear to be ideal places for an ex-addict to re-establish himself. Moreover, public education would be necessary, so that the former addict can be accepted by the community, and *particularly* by his new employer. Understanding and acceptance are essential.

I have not covered the investigations made by members of this force in the province of Quebec, of professional and medical addicts, as this subject has already been dealt with by persons of greater competence. Suffice to say that we have no reason to believe that professional addicts obtain their supply from criminal peddlers. As for the medical addicts; only a few instances have occurred where such addicts turn to the criminal peddlers for their supply. In most cases, such medical addict is not addicted to heroin and usually obtains his supply from sources other than the criminal peddler.

A final note on conspiracy. In this province we have used to excellent advantage the charge of conspiracy to commit an infraction of the Opium and Narcotic Drug Act. Usually the top men in illicit drug transactions do not take an active part in the supply and distribution of such drugs. They may merely put up the money, or "trigger" some part of the clandestine importation, or perform some "background" act in the transaction. Such persons have been charged with conspiracy. Likewise, those working at lower levels have so been charged, with eminent success. Twelve persons are before the courts at present on charges of conspiracy to traffic in drugs. The conspiracy section of the New Criminal Code provides the same penalty as that under the substantive offence. By this means we can attack everyone from the "kingpins" to the lowest addict.

The CHAIRMAN: Honourable Senators, are there any questions any of you would like to ask the witness?

Senator HODGES: I have a question I would like to ask the Superintendent. I think you are the first witness we have heard who suggested that a continuous and vigorous attack on the traffickers is not the answer to suppression. You think we should go after the addicts, rather than the traffickers? I think yours is the first suggestion we have had along that line, and I wonder why you are of that opinion.

Superintendent BRAKEFIELD-MOORE: Through experience, we have found that as soon as the "top people"—shall we say—are apprehended, there are others immediately ready to take their places. We have instances where people have been removed from circulation, and our undercover agent has been immediately approached to say that so-and-so will now supply the "stuff".

So we have been forced to the conclusion that while we still vigorously attack the top people, and those in the middle, shall we say, to root out the addicts themselves would, in effect, remove the demand for the drug, and in that way put the higher echelon out of business.

Senator HODGES: Another thing we have been told, Superintendent, is that every addict is almost invariably the cause of the creation of more addicts. Have you found that to be the case?

Superintendent BRAKEFIELD-MOORE: The figures supplied indicate that in the City of Montreal, 25 new addicts were added during the past three years.

It is true that, as I have said, "misery loves company", and that a company of drug addicts is more strongly bound together than the members of any fraternal association, and new addicts are created by the older addicts.

I have no figures of the incidence of new addicts, but it would appear that the proportion is much lower than was stated in the question.

Senator HODGES: If you have only about 100 criminal addicts in Montreal, how do the top traffickers make enough profit to warrant them in carrying on? Do you think that this is the distributing point for the rest of Canada?

Superintendent BRAKEFIELD-MOORE: The supply of narcotics even to those known 100 criminal addicts would account for a very lucrative business, apart from any other consideration.

When you consider that the average user takes from four to eight capsules per day, at an approximate price of \$5.00 per capsule, you will understand what I mean, and bearing in mind the tremendous margin of profit, the larger traffickers can still make a tremendous profit. Not all the drugs, as I have mentioned, find their way into this area here, but sometimes are shipped to other areas.

Senator HOWDEN: Superintendent Brakefield-Moore, suppose the traffickers were exposed to a very much more severe punishment than in the past—for instance, a life sentence—they can be gathered up, even if we had to put an army behind the bars, and keep them there. Do you not think that would have a good effect?

Superintendent BRAKEFIELD-MOORE: Certainly, the removal of the addict from the scene—

Senator HOWDEN: I am speaking of traffickers.

Superintendent BRAKEFIELD-MOORE: There are two types of traffickers, the addict trafficker—the peddler, and the non-addict type.

The CHAIRMAN: I think the honourable Senator was speaking of the higher-up men—the men at the top.

Senator HOWDEN: It is the men at the top who actually supply the money, irrespective of who the addict might be.

The CHAIRMAN: I think Senator Howden is trying to ascertain if the sentence were heavier, it might deter the men in the higher brackets.

Superintendent BRAKEFIELD-MOORE: Our experience has shown that when people are removed from this illicit trade, they are immediately replaced by others, and that even the exemplary sentences handed down by the courts have not been too great a deterrent.

Even if life imprisonment were given, one might reasonably suppose that the supply would still continue; that others would supply it, who were willing to take the chance because of the terrific profits involved.

Senator HOWDEN: I can understand about the tremendous profits involved, but I would think our local officers could gather them all up in time, and if they all got life sentences, they would be a little bit chummy about taking over from somebody else.

Senator LÉGER: What is the average age of your addicts in Montreal?

Superintendent BRAKEFIELD-MOORE: I regret not having those figures available.

Senator LÉGER: What would be the youngest?

Superintendent BRAKEFIELD-MOORE: The youngest would be approximately twenty. We did have one instance of a sixteen-year old, but we know definitely he is not on the drugs. He is a useful citizen at the moment.

Roughly, our figures agree with the figures I have already supplied to the Committee.

Senator BIRCHILL: Superintendent Brakefield-Moore, for a city the size of Montreal, and it being a seaport, and everything else, you seem to have a very light problem here. Would you care to comment on the reason for that?

Superintendent BRAKEFIELD-MOORE: I believe a partial reason at least, might be twofold. First, the very rigorous enforcement programme undertaken by both the Royal Canadian Mounted Police, and the Montreal City Police, working in close co-operation. This work has been going on very rigorously, to my knowledge, for some thirty-five years. We now enjoy the fruits of that rigorous enforcement programme.

Secondly, we have found that organized crime, as I have stated before, and drugs, do not necessarily go hand-in-hand. In other words, organized crime—that is, the more serious types of crime—is not for the addict, because the addict is notably the most untrustworthy person. If he misses a “shot” or two, he is likely, in the minds of the criminals, to turn “stoolpigeon” and “give the game away”.

Senator BIRCHILL: Has the volume of traffic over the thirty-five years of which you have just spoken, shown a satisfactory decrease, in proportion to your population.

Superintendent BRAKEFIELD-MOORE: I regret again not having an accurate answer, but it would seem that such is the case. The down curve has been fairly steady, with fluctuations here and there, of course.

Senator HORNER: Superintendent Brakefield-Moore, what percentage of those of whom you know are women, in Montreal?

Superintendent BRAKEFIELD-MOORE: I could only give an approximate answer to that. I would say between twenty and thirty.

Mr. LIEFF: What is the price of a “cap” today?

Senator HORNER: That seems remarkable to me, because the evidence we heard in Vancouver was to the effect that there was difficulty experienced at the beginning, where women were starting at sixteen, and in order to get a supply, they would live as commonlaw wives and things of that sort. They appeared to have quite a percentage in Vancouver, according to the evidence.

Senator TURGEON: These drugs come in illegally and in large quantities from other countries, and I was wondering if there was any possibility of preventing the importation and “killing it” at the port of entry, to prevent drugs from getting into the country.

Superintendent BRAKEFIELD-MOORE: We, of course, work very steadily and strenuously on that angle by checking incoming boats, and aircraft and by checking the border points when and as possible.

But the problem is so tremendous in a large metropolitan area such as this, that it is very difficult to seal off the border, as it were, 100 percent. All we can do is our best. We know the stuff still gets in, despite our vigilance.

Senator VAILLANCOURT: I am happy to hear that the narcotic problem in Montreal is under control by your organization, but have you the same control outside the city, especially at the United States border?

Superintendent BRAKEFIELD-MOORE: We have checked elsewhere in the province, of course. Every detachment member in this province has had a certain amount of drug training; they are aware of the problem, and are on the lookout for illicit drugs.

When a case becomes serious enough, our Montreal squad is called in.

We keep a vigilant eye along the United States-Canadian border, and our information has been to the effect that there is very little entering illegally and it almost entirely ends up in metropolitan Montreal.

In Quebec City, we have a member, experienced in drug work, and he does as much work as is necessary in that city, because of its being a trans-Atlantic terminal, and he also patrols the American border between the northern part of the State of Maine and our province.

Senator VAILLANCOURT: I have some information that at the border in Beauce County some people travel across the border at places other than highway points, and transport narcotics. We have some difficulty in localities from Beauce to Quebec City.

Superintendent BRAKEFIELD-MOORE: Sir, such traffic has not come to our attention in any appreciable amount.

As I mentioned toward the end of my submission, we have not dealt too much with the professional and medical addicts.

Our main concern is with the smaller groups of local people in the vicinity of the border bringing over illicit goods from the United States, and from the forests of Maine, and so on.

Our experience has been that, to our knowledge, there has been very little in the trafficking of drugs.

Senator HOWDEN: So it does not appear to be a great danger—nationally?

Superintendent BRAKEFIELD-MOORE: At the moment, it is not. There are not the facilities for this small number of people to put up the large amount of money required to make the wholesale trafficking worth-while. In small amounts it could be done, but I am sure it would come to our attention in very short order, and any suggestion would be immediately investigated, within a matter of a few hours.

Senator BAIRD: For instance, Superintendent Brakefield-Moore, a person going abroad, then coming back here, will go through the Customs. They do not encounter any Mounted Police, and they might easily bring in drugs, or anything else.

For instance, you spoke of keeping a close "tab" on the border. Of course, that is your duty, but what close "tab" do you keep on people going and coming through the Customs?

Superintendent BRAKEFIELD-MOORE: The border, being such a large one, with only a comparatively few Customs ports, and with so many side roads where there are no Customs ports, the ease of smuggling makes our work exceedingly difficult. However we do have Highway Patrolmen operating, who will make "spot checks" as and when possible.

Senator BAIRD: There could be a great deal coming through, and you not know it?

Superintendent BRAKEFIELD-MOORE: There could be, but when it landed in metropolitan Montreal, we would, through our contacts, know about any shipment of small amounts when it arrived.

Senator KINLEY: Are the United States authorities active in endeavouring to control this traffic?

Superintendent BRAKEFIELD-MOORE: I have no information on that.

Senator KINLEY: I thought you might have your work co-related with theirs.

Superintendent BRAKEFIELD-MOORE: We work very closely with them, wherever it is possible.

The CHAIRMAN: Superintendent Brakefield-Moore, you mentioned six countries, France, Italy, North Africa, the United States and Mexico. I suppose you have facilities to make it possible to ascertain the country of origin of these narcotics?

On the other hand, have you any information in regard to drugs coming into the West Coast area from China?

Superintendent BRAKEFIELD-MOORE: I mentioned those six countries in connection with the investigation of a particularly large case.

As for importations along the West Coast; I believe the answer would be in the negative. We have no information that any appreciable amount of drugs are coming into the West Coast of Canada.

Senator HOWDEN: Superintendent Brakefield-Moore, we were told in Vancouver countless times of the ruination of young women coming from respectable families—families in good circumstances—who were taken in tow by traffickers, and taken out and wined and dined, and one thing and another, and eventually ending up as prostitutes to earn the money for the drugs, that is, by selling their bodies.

Have you any such circumstances, to your knowledge, in regard to Montreal?

Superintendent BRAKEFIELD-MOORE: The incidence of that type of new addicts would not be very high in Montreal. I think perhaps our friends on the Montreal City Police might more readily and accurately answer that question, sir.

Mr. LIEFF: How large a drug squad do you maintain here?

Superintendent BRAKEFIELD-MOORE: At the present time, we have a squad of eight men, and whenever necessary, that squad is added to.

Mr. LIEFF: From your other people?

Superintendent BRAKEFIELD-MOORE: From our other people, yes, who are engaged in general investigation work.

We can put on as few or as many men as necessary on a particular job.

Mr. LIEFF: I take it from your paper that the relationship between your Force and the City Force of the City of Montreal is satisfactory at the moment?

Superintendent BRAKEFIELD-MOORE: Entirely satisfactory.

Mr. LIEFF: You have no suggestion to make about that, generally?

Superintendent BRAKEFIELD-MOORE: None at all. Our present mode of working together, and our fields of endeavour are quite co-ordinated, from the Royal Canadian Mounted Police angle, and we are extremely happy along that line.

Senator HUGESSEN: Do you find the present law quite adequate, or have you any suggestions for changes either in the Criminal Code or the Opium and Narcotic Drug Act?

Superintendent BRAKEFIELD-MOORE: We are, at the moment, assessing the application of the new Criminal Code as regards conspiracy, and so far it appears to be working exceptionally well. The new Section 4 of the Opium and Narcotic Drug Act dealing with traffickers has been of tremendous help to the law-enforcement officials, and at the moment, it would seem that we have good machinery for combating this type of crime.

The CHAIRMAN: Would you care to tell us the sentences usually handed out here, beginning with the ordinary addict, and going right to the top? You mentioned:

Seventy-five persons associated with trafficking or as users of narcotics now in penal institutions.

Superintendent BRAKEFIELD-MOORE: Yes, I mentioned 75 persons who were associated with trafficking or as users of narcotics are now in penal institutions, ranging from a few months for trafficking—

Senator HODGES: "A few months for trafficking"?

Superintendent BRAKEFIELD-MOORE: I am sorry. I will correct that. I meant a few months for addicts.

That goes up to four and five years, which are fairly common sentences for trafficking.

Mr. LIEFF: What has been one of your longest sentences for trafficking I notice you say:

In a major undercover investigation during 1950-1951, which led to the arrest of seven traffickers operating on a national and international level. Our undercover member, acting as a trafficker over a period of 20 months, was able to work his way up from buying a few ounces of heroin from a local "boss" of street traffickers through association with addicts and street peddlers.

The result was that at the end of the investigation, he was contracting to purchase heroin by the kilogram from the then "king pin" in the wholesale traffic in Eastern Canada.

Superintendent BRAKEFIELD-MOORE: I am afraid again I cannot submit accurate information on that, but I believe it was very substantially greater than the maximums I mentioned so far.

The CHAIRMAN: This appears to be the very highest men at the top. You said you picked up seven in 1950 and 1951, and I was wondering what kind of sentences were meted out.

Mr. LIEFF: You can get that information for us?

Superintendent BRAKEFIELD-MOORE: Oh yes, I can secure that information. At the moment, I have not it with me.

Senator HORNER: What is the position in which you are now placed in regard to conspiracy? You are not in a position to say there are so many addicts in the jails, and so many out? With the law as it is at the present time, you cannot arrest a person because you believe he is an addict, because he would simply become ill if you keep him away from the drug.

Apparently it is not an offence to take the drug, but only to sell it.

Superintendent BRAKEFIELD-MOORE: One of the offences is the possession of drugs—having a drug in his possession.

Senator HORNER: You may know he is an addict, and yet not have it in his possession. You could only learn whether he was an addict or not if you got him away from it?

Superintendent BRAKEFIELD-MOORE: Those people are kept under close surveillance, and when they are seen to "make a buy", that is the time they are apprehended for being in possession of narcotics illegally.

Senator LEGER: Some years ago, I believe you arrested one of the top men who was allowed out on bail of \$5,000.00, and skipped his bail. Has he been recaptured as yet? I believe his name was Ciro, or something like that.

Superintendent BRAKEFIELD-MOORE: I understand he is at present in custody in the United States of America, and legal proceedings are now under way.

Senator LEGER: That offence took place in Montreal?

Superintendent BRAKEFIELD-MOORE: Yes.

Senator HORNER: Just one further question. You mentioned the desirability of placing those who are addicts in some institution. Would you go so

far as to recommend a place similar to the one in Lexington, Kentucky, where they have a very close follow-up system? Do you think that sort of thing would be of any help in Canada, a real attempt at cures and rehabilitation?

The CHAIRMAN: Rather than just putting them in jail?

Superintendent BRAKEFIELD-MOORE: Our experience—

Senator HORNER: Would you recommend that?

Superintendent BRAKEFIELD-MOORE: Our experience has been that the time spent in jail in regard to the curing of addiction, is absolutely useless. Within hours of their release, the addicts are back on the habit again, in most cases.

We feel that some sort of an institution where cures might be undertaken, and where useful trades might be taught, would be a good thing. We believe that where the elementary essentials of good citizenship are taught, it would be most useful, but a very well-controlled parole system would be necessary, because despite all that, there is something in the physical make-up of an addict which causes him to return to the addiction.

As I have said, it is like a fraternity. The bonds are very strong, and it is very difficult to eradicate the desire to return to the drugs. I think that public education and the acceptance of these people as citizens—

Senator HORNER: Would you recommend an institution of this kind be placed at some distance from the larger centres, out in the smaller communities?

Superintendent BRAKEFIELD-MOORE: A sufficient distance to keep them away from their former haunts—that is, from their former locale.

Senator HOWDEN: Would that include incarceration, that is, sending them away from an easy contact with the drugs? There would be no good in having them free; you would have to incarcerate them?

Superintendent BRAKEFIELD-MOORE: Until announced by competent medical or psychiatric authority that they are reasonably cured. Then the process of rehabilitation starts.

Senator KINLEY: After they have been pronounced cured by competent medical authority?

Superintendent BRAKEFIELD-MOORE: Yes.

The CHAIRMAN: Has any honourable Senator any further questions to ask of the Superintendent?

Senator KINLEY: I see in your paper, you say:

As elsewhere in Canada, the criminal addict makes use of heroin almost exclusively. Even the few oriental addicts to be found in the Montreal district are users of heroin. Opium and morphine, which were the drugs of addiction prior to the Second World War, are seldom encountered in this province nowadays.

Are you eliminating cocaine altogether?

Superintendent BRAKEFIELD-MOORE: We run into cocaine very rarely now.

Senator KINLEY: It used to be quite common?

Superintendent BRAKEFIELD-MOORE: I believe it formerly was. We run into heroin almost exclusively at the present time.

Senator KINLEY: And that is prohibited?

Superintendent BRAKEFIELD-MOORE: Yes.

Senator KINLEY: Is there any indication that there is any advantage from a profit point of view in what they are using now? We have been told that the prohibition is only accentuating the use. However, we were also told that in regard to liquor, in the days of Prohibition.

Superintendent BRAKEFIELD-MOORE: I think the main factor in this is that heroin is three times as strong, and gives a more satisfactory "lift" to the user than any other drug. The matter of the legality or otherwise of this drug is not of first importance to the addict.

Senator KINLEY: The price is extremely high?

Superintendent BRAKEFIELD-MOORE: The price is not too important to the addict, as long as he can get the price, so all his energies are bent in getting the price, whatever it may be.

Senator KINLEY: You think he will commit crime to get the money to support his addiction?

Superintendent BRAKEFIELD-MOORE: Most of the times, yes.

Senator LEGER: Have you any Orientals using drugs here?

Superintendent BRAKEFIELD-MOORE: Again I have no accurate figures, but I would say the figures are comparatively low.

Senator HOWDEN: The duty of this Committee is to study the use of narcotics, and the traffic in them, and if at all possible, we would like to look forward in the end to some suggestions as to how the prevention of the use of drugs may be brought about. Have you any plan in your mind?

Superintendent BRAKEFIELD-MOORE: With our present mandate, sir, we will, as in the past few years, at least—and probably more so—continue to fight against the trafficker, the "king pins", as we call them, and also to keep the addicts stirred up, and keep after them, and, in this province at least, to seek to remove the demand for the drug by putting as many addicts as possible out of circulation, through due process of law, of course.

Senator HOWDEN: And you start at the bottom, with the addicts? You incarcerate them, and subject them to a subjective cure, and thereby hoping to do away with the trafficking?

Superintendent BRAKEFIELD-MOORE: That is generally correct, sir, the removal of the demand for the drugs completely. If the demand has gone, the trafficker is left without any customers.

Senator HOWDEN: Do you think it is possible to gather up all the addicts, and put them out of the way?

Superintendent BRAKEFIELD-MOORE: As I say, in this Division, we make it our aim, as far as is humanly possible.

Mr. LIEFF: You have kept them "on the run"; you do not permit them to get "bedded down", nor allow them to become too comfortable in this community?

Superintendent BRAKEFIELD-MOORE: No. Again, through co-operation with the city police, we have splendid sources of information and those, together with our own sources of information, enable us to keep close "tab" on them.

Mr. LIEFF: It is all-out police work, all the time?

Superintendent BRAKEFIELD-MOORE: Yes.

Senator HOWDEN: Several times it has been suggested that we have clinics where drug addicts could obtain drugs either free or at a very low cost. What is your opinion of that? Would you be in favour of such a scheme?

Superintendent BRAKEFIELD-MOORE: We, in this Division, would be very much against that, I am afraid.

The CHAIRMAN: Have honourable Senators any further questions to ask of the witness? (No response.) If not, may I say, Superintendent Brakefield-Moore, that we thank you very much for coming here this morning and for the information you have given us. On behalf of the Committee, I do wish to thank you.

Superintendent BRAKEFIELD-MOORE: Thank you, Mr. Chairman and honourable Senators.

Superintendent Brakefield-Moore retired.

Mr. ROBITAILLE: May I ask a question, Mr. Chairman?

The CHAIRMAN: If it is a question, yes, you may ask it.

Mr. ROBITAILLE: Are there any figures to substantiate the fact that in the last five years we have had over 200 prostitutes on probation in Montreal, and of those, I do not know of any who were using drugs.

The CHAIRMAN: We had evidence in Vancouver that there were prostitutes who were on drugs, living with addicts, and selling their bodies in order to obtain the price of the drugs.

The CHAIRMAN: Our next witness is Mr. Thomas Leggett, the Director of Police, of the City of Montreal, whom I will now ask to come forward.

Thomas Leggett (Director of Police, City of Montreal, P.Q.).

The CHAIRMAN: Will you proceed, Mr. Leggett?

Mr. LEGGETT: Mr. Chairman, honourable Senators and gentlemen: when I heard that your Committee was coming to Montreal, I was very happy indeed that you were going to pay us a visit, but when I was told of the type of investigation you were conducting, I found it very difficult to prepare a paper in which I could offer you some suggestions. I felt, therefore, that it might be better if I were to appear before your Committee, and answer any questions any of the honourable Senators might care to ask.

I would like to tell this Committee that we, as the Police Department of a large metropolitan city, feel that we can best handle drugs and drug addicts with a special squad, always, of course, considering the Royal Canadian Mounted Police as the main body. We have with that service, the closest co-operation it is possible for any Police Department to have. I believe that without that co-operation, we would, indeed, have a problem in Montreal.

I am not here to tell you what a good job the Royal Canadian Mounted Police are doing, as I can only speak for the Department which I represent, but I do feel that the drug situation in our city is well in hand from a police point of view.

Senator HAYDEN: It is no major problem here?

Mr. LEGGETT: Far from it. I wish some of our other problems were just as good and as well under control as our drug situation.

I repeat to you gentlemen—and I think this is a most important thing I have to say—that I believe without the co-operation of the senior police service, the Royal Canadian Mounted Police, our drug situation here would not be under the control that it is today.

We have done some work, and are very happy at what we have been able to accomplish in order to control this situation, but no doubt the senior service has played the major role.

Our Department receives information from many sources, consisting of all types, and I think it would be a very difficult thing for any drug ring or organization to install themselves in our city, without our hearing about it. If we do hear even the most vague rumour that such a situation does exist, our detective bureau would immediately contact the Royal Canadian Mounted Police, and make them aware of it. That is why I say to you that in regard to the drug situation, I believe we can say we have no problem. Of course, we do have some trouble with it, but very little. I repeat again that I wish all our other problems were under such a good control as the drug situation.

Honourable Senators, if there are any questions you would like to ask of me, may I say that I have the Chief of the Detective Division here (Mr. Allain), and also our Assistant Director of Police (Mr. Plante), who specializes in morality questions, and I am sure that between us we may be able to answer any questions you care to ask. If it is something about the policy of the Department and the general administration, I am in a position to answer. If it concerns drugs, I am sure our Chief Detective can answer your questions, and so can our Assistant Director of Police, Mr. Plante.

Senator HOWDEN: I think if you have no major problem here, you are very fortunate. You have here very different conditions from those we have seen elsewhere, and I do not think we need to bore into the activities of your Police Force, when we find such a healthy condition existing here. You have told us you have no major problem here, and we consider that a very good thing.

The CHAIRMAN: It might be advisable for the Committee to hear Chief Detective Allain, of the Montreal Police Force.

Senator BURCHILL: Mr. Leggett, would you agree with the statement the Superintendent of the Royal Canadian Mounted Police made, that the present happy situation is due to the effective measure of co-operation between the Royal Canadian Mounted Police, and the City Police Force of Montreal?

Director LEGGETT: I agree with that 100 per cent. It is good policing and co-operation, and he is certainly able to come before this Committee and make that statement.

The CHAIRMAN: May I ask this question? Is it a fact that years ago, the problem was more severe than it is today, and, if so, just what method was taken to make it better?

Director LEGGETT: I think the co-operation between the two services is a little closer today than it was in former years. We understand the problems of each other much better, and we have come to realize in any major problem that we have to have co-operation between all Police Departments, to be successful in controlling this type of crime.

Senator HUGESSEN: You have told us of the present remarkable situation, and, as the Chairman asked, has it always been so, or has there been a drop in the last few years?

Director LEGGETT: That would be a hard question to answer, Senator Hugessen, because you can only state it as you see it. We, in the police, are prone to forget the past, and to look into the future. I think most police officers do that. We are looking at the present, and into the future.

Senator HOWDEN: Would it be because of the harrying by the Montreal Police, and the Royal Canadian Mounted Police in this Division, that we have so many in Vancouver? Have your drug addicts and criminal addicts gone to Vancouver?

Director LEGGETT: I will try to answer that, because I happen to know a little about the situation in the world today, and I would say the situation in Vancouver is entirely different than in Montreal, and I do not think it would be fair to compare Vancouver with Montreal. There you have a seaport, and for many, many years, you have had trouble with drugs being imported into the country by way of the boats docking in Vancouver.

Senator HOWDEN: We were told out there that one of the largest sources of supply was from Toronto and Montreal.

Director LEGGETT: It was not very kind of whoever said that, to make a statement of that kind. I would doubt that statement very, very much, because we should all endeavour to be factual in making out statements.

Why would they send it through Montreal, when there are other locations much closer, capable of handling it?

Senator STAMBAUGH: What is your position as "Director"? Is that equivalent to the "Chief of Police"?

Director LEGGETT: That is right, Senator, yes.

Director Leggett retired.

The CHAIRMAN: Our next witness is Chief of Detectives, George Allain, whom I will ask now to please come forward.

George Allain (Chief of Detectives, Montreal Police Force, Montreal, P.Q.).

The CHAIRMAN: Will you please proceed, Chief Allain?

Chief of Detectives ALLAIN: Mr. Chairman and honourable Senators—

The CHAIRMAN: If I may just interrupt at this moment, Chief Allain.

Honourable Senators, before Mr. Allain proceeds with his evidence, it has just been drawn to my attention that we are invited by the Mayor of Montreal to have luncheon at twelve-thirty. It takes about twenty minutes to drive down there, so I am told, and I think personally I would not like to have Mr. Allain commence his evidence, and not have to break into it in the middle. I think we would all prefer to have his statement made at one time, rather than have him start, and then have to interrupt him.

If it is the pleasure of the Committee, we will stand adjourned now to reconvene at two o'clock.

—Chief of Detectives Allain temporarily retired.

At 12.05 p.m. the Committee adjourned until 2.30 p.m.

AFTERNOON SESSION

The Committee resumed at 2.30 p.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable Senators, we have a quorum, and I think we should commence our afternoon sitting.

Mr. LIEFF: Mr. Chairman, with your permission, this gentleman is Chief of the Detective Bureau of the Police Department of the City of Montreal.

GEORGE ALLAIN (*Chief of Detectives, Montreal Police Department*), previously called, and now re-appearing, before the Committee:

The CHAIRMAN: Will you proceed, please, Chief Allain?

Chief ALLAIN: Mr. Chairman and honourable Senator; I do not think there is much I can add to what was said this morning by the Superintendent of the Royal Canadian Mounted Police, Mr. Brakefield-Moore, and by Chief Director Leggett.

In every city of this size, they do have a drug problem, but we are lucky in this city that it is not a big problem, and that is something the Chiefs of any police organization should never lose sight of, because if the situation is neglected, it very soon gets out of control.

I have been thirty-one years in police work, and on this Police Force. I have only been in charge of the Detective Office of the City of Montreal since December. When I took charge of the office, it was the wish of Director Leggett that we co-operate with the Royal Canadian Mounted Police more than had been done in the past. Incidentally, that was also my wish.

Since that time, I will not pick up a drug addict or a peddler on the street until I contact the Royal Canadian Mounted Police. There are certain reasons for that. We know that the Royal Canadian Mounted Police spend a great deal of money and time on the men who are doing that work, and if anybody should work independently without consulting them, it might have the effect of spoiling a case upon which they have been working for a long time. That is the main reason why we feel it is very important that we should keep in close co-operation with the Royal Canadian Mounted Police.

There is one thing for which we are very grateful in Montreal, and that is we have never had any school or institution reporting any of its students or pupils using drugs.

I think that is about all I can tell you, unless some of the honourable Senators may have some questions they would like to ask.

Senator HOWDEN: Chief ALLAIN, you do not think the narcotic drug problem is a big problem in Montreal?

Chief ALLAIN: No, it is not.

Senator HOWDEN: You do not think it is a great threat to the citizens of the City of Montreal?

Chief ALLAIN: At the present time, it is no threat, because it is well under control.

Senator HOWDEN: You think the City of Montreal would be pretty well advised just to keep on with the program, under which you are operating now?

Chief ALLAIN: Yes, I do, Senator.

Senator HOWDEN: There is no necessity, in your opinion, for any further action—any more action?

Chief ALLAIN: Oh, Senator, I would not say that. There is one thing I have in mind in answering your question, and that is this: these addicts—as was told to you by Superintendent Brakefield-Moore this morning—might be in custody for eighteen months, or even more, or perhaps less, and get “off the drug”, but just as soon as they come out, they go back on to the habit again.

I think the men should come out on parole, and be compelled to report to some doctor or psychiatrist, who could keep “tab” on them, and if they are found to be on the drug habit again, back they go into custody.

Senator HOWDEN: Would you require a daily report?

Chief ALLAIN: I would not say a “daily report”, but they should report once or twice a week to some doctor, or to somebody who would be able to appraise the situation.

Senator GERSHAW: Would you tell us anything regarding the home lives of the few addicts you have in Montreal? Do they come from broken homes? Have they delinquent records? Are their living conditions good? Do they get enough food, and so on?

Chief ALLAIN: Not necessarily. I know of a man who came from a very prominent family in Montreal, and who had been on the habit all his life. He probably is dead now, because when I lost sight of him, he was over fifty years of age, and he had always been on the habit. With such a man, even with good enforcement, I do not think he could be helped to any great extent to get away from drugs.

Senator HODGES: You say there are 100 criminal addicts in Montreal? Do you know of any others here?

Chief ALLAIN: Yes, I know of some, some professional men, doctors, lawyers, and so on. But these people do not create a problem.

Senator HODGES: You have had other addicts than the criminal addicts?

Chief ALLAIN: Oh, yes, Senator.

Senator HODGES: You know they are addicts?

Chief ALLAIN: Yes.

Senator HODGES: There are a number of other people who take drugs?

Chief ALLAIN: Yes.

Senator HODGES: Have you any idea to what extent?

Chief ALLAIN: No. I think the number is so small, it would be hard to answer that question. There are, of course, cases about which we never hear. It is just the same as with the drunkards. People have been drinking all their lives, and we do not know about it.

Senator HORNER: We will have to bring in a report, and present our recommendations. One of your men suggested—and it has been suggested by various police enforcement officers and detectives—the great difficulty they have when they find a sale has taken place, to find a person in illegal possession of the drug. You say you know there are criminal addicts loose in Montreal?

Chief ALLAIN: Yes, there are.

Senator HORNER: Would it be possible, or reasonable, for us to recommend that you arrest these people, and hold them for proof? Or is that illegal? If they were liable to arrest, would you be in a better position to stamp out the traffic? That is, if you could arrest these people, and hold them, especially if you establish some place for something like a cure, where you might get them off the drugs? Would that be of any great help to you?

The CHAIRMAN: Before you answer that, Chief Detective Allain, may I add one word to Senator Horner's question?

It was brought out in Vancouver that drug "pushers" were carrying one or two little capsules in their mouths, and when the police approached them, they swallowed the little bags. The police said they had a great deal of difficulty in that respect, as they could not hold a man, although they knew that he had swallowed the drug. They had no way by which they could hold him, and endeavour to prove it.

Senator HORNER: That was not exactly my meaning, Mr. Chairman. I have been informed they can tell by the appearance of a man's arm when he is arrested, but they cannot hold him, even though they realize he must be an addict, but they have no present authority, under the current Criminal Code, to detain that man, if they cannot find drugs on him, or see him making a sale, even though he is known to be an addict.

The CHAIRMAN: Do you find any difficulty along that line, Chief Allain?

Chief ALLAIN: That is in line with what I said a moment ago. The addicts out of custody, should be on parole, but as the law is today, it would not be legal to pick up a man just because he is an addict, but if we can make out a case against him, we can place him in confinement, and I think perhaps the law might be amended, so that we could, in future, arrest him for being an addict, or if he was under supervision, and the supervisor warned us he was going back on the drugs, we could pick him up without another order from a magistrate.

Senator HORNER: You cannot do that today?

Chief ALLAIN: No, we cannot do that today.

Senator HORNER: You think that would be of great help to you?

Chief ALLAIN: Yes. It would be of great help. The addict would be afraid to go back to his vice again, because he would know we could pick him up.

Senator HORNER: It might be difficult with the older addicts, but it might be useful in connection with the very young.

Chief ALLAIN: I think it would be equally good for both.

Senator BURCHILL: How long have you been in your present position?

Chief ALLAIN: As Chief Detective?

Senator BURCHILL: Yes.

Chief ALLAIN: Since December.

Senator BURCHILL: I am very much interested in the trend here in Montreal. You agree with what has been said that it is under control, but have you anything to show that it may be on the wane?

Chief ALLAIN: I think at the present time it is at its lowest ebb.

Senator BIRCHILL: You have nothing in your mind in connection with the suggestions you just made, which you would suggest to the Committee as a recommendation in the way of changing the Act or the law, which would help you in your enforcement work?

Chief ALLAIN: I may have something in my mind, but it would not be for me to suggest it. I do not know whether the Royal Canadian Mounted Police see it the same way I do or not.

I think the more co-operation you give to the Royal Canadian Mounted Police, the better, because we know the Royal Canadian Mounted Police are very competent in that line, from the Atlantic to the Pacific Oceans, and especially internationally. They get more details of what is going on, and can keep better track of the addicts in Canada. They can keep better control of it, with the help of an inferior department. We do not want to possibly spoil a case for them by acting independently. I think this will lead to greater success, in regard to the whole matter. You can easily realize that we could very quickly spoil a case, as I have already explained, if we worked independently. I could easily arrest a "pusher" or an addict, but, at the same time, I might be doing a great deal of harm to a case being made by the Royal Canadian Mounted Police, who perhaps have spent a great deal of money on the case, but have decided it is not just the proper time to make an arrest. By holding back a little, they might be able to bring about the arrest of a big distributor, and the fact that I may have taken one fellow out of the link of their case, might make it extremely difficult for them to complete the work they have already started.

The CHAIRMAN: If drug addiction is spread from one addict, to someone starting in to take drugs for the first time, how can you keep down the increase in the drug addiction? We have been informed this morning there were only 25 in Montreal. How do you keep it down? We have been told that drug addiction is spread from one addict to the others. In that case, how do you keep the increase down?

Chief ALLAIN: I think, myself, if the police work to keep after the "pushers" especially—the ones who go from the small distributors to the addicts—if we can prevent them from working, it has the effect that the addict is not getting his drugs, and then the distributors would suffer, if we could keep the "pushers" off the streets.

The CHAIRMAN: Do you keep moving them around, and stirring them up, by picking them up and taking them before the courts?

Chief ALLAIN: Yes. They know very well they are being watched and they dare not take any chances.

At the same time, we know where they congregate and whom they meet, and if they meet a policeman once in a while, they have to change their ways of getting their drugs. There are a hundred different ways in which they can secure it.

The CHAIRMAN: Do your police follow them around, while in uniform?

Chief ALLAIN: No. They always work in "civies".

Senator BAIRD: Do I understand rightly that if you see a "pusher" soliciting a client, you cannot arrest him?

Chief ALLAIN: How would you know what he was saying?

Senator BAIRD: He remains free, and can move about unmolested?

Chief ALLAIN: Yes. They certainly do not bring along any witnesses. They might be talking about drugs, but if an ordinary person heard them, he would not know they were talking about drugs, because they use some kind of a code, and the ordinary man would not know what they were talking about.

Senator BAIRD: In other words, it may require some time before you can get hold of a "pusher"?

Chief ALLAIN: Yes.

Senator BAIRD: It might even take years?

Chief ALLAIN: Yes, but we keep a record of those with whom they are congregating. If he keeps meeting another person, it generally means they are in it together.

Senator KINLEY: Have you the power to search?

Chief ALLAIN: Whether we have or not, we do it.

Senator STAMBAUGH: I was late in arriving this afternoon, but from hearing what has gone on since I did arrive, did you suggest the law should be changed to make it illegal to be an addict?

Chief ALLAIN: Yes.

Senator LEGER: Do your "pushers" use cars?

Chief ALLAIN: I think they use all kinds of locomotion, but they use cars mostly.

Senator LEGER: Have you any cured addicts?

Chief ALLAIN: I cannot give you any figures. I know one fellow who was a big addict, and for ten years he did not touch it. I think he married a nurse, and she—

Senator HODGES: Kept him off of it?

Chief ALLAIN: Yes.

Senator HODGES: In regard to the criminal addicts; do you not have records of those coming before you again and again?

Chief ALLAIN: I wanted to find out how many we arrested since January, 1947. I found out we had 86, and out of the 86, we had 13 repeaters. Some of them repeated very often, while some of them may have only repeated a couple of times.

Senator HODGES: You find the length of sentences does not make any difference in regard to the likelihood of them returning to the drug habit?

Chief ALLAIN: No. I think if a fellow was kept away from the habit long enough, and then put on probation where, as I say, he would have to report someplace, if the law permits it, and if he went back into his vice again, we could pick him up without any further court action.

Senator HODGES: Another question I would like to ask. Do you find—as we have been told before—that the average criminal addict is associated with the more violent types of crime, or is it generally just petty thieving, and shoplifting?

Chief ALLAIN: I think most of them are shoplifters, and breaking into stores and private houses.

Senator HOWDEN: You do not find they commit the major crimes?

Chief ALLAIN: No. If we arrest them for a bank holdup, for instance, they might get four or five years, and they are afraid of losing their drug for

that length of time. If there were any who committed bank holdups, and crimes of that kind, it was not very frequent. They generally go for something they can get fast money on to get the drugs.

Senator KINLEY: Do they get along without the drugs for a very long time?

Chief ALLAIN: That I cannot answer, but if a man is a heavy user, he has to be treated. It is like a man who comes off the drink. If he keeps off of it for six or eight months, he would not feel the effect of taking a drink.

Senator HODGES: Do you segregate drug addicts here from the other criminals, or are they all together?

Chief ALLAIN: I believe they are kept together, but I cannot make that statement definitely.

Senator HODGES: To what extent do they mix with the other criminals?

Chief ALLAIN: I have no definite information on that, Senator.

Senator HODGES: They are not segregated?

Chief ALLAIN: No.

Senator HORNER: In regard to some parole system; would it pay to advertise for volunteers who would employ these people after they were at least temporarily cured—who would volunteer to give them employment, and keep them away from the habit?

Chief ALLAIN: I think anything that would be done, the better the situation would be. I have heard lately there was such an association, which I think is called the "Narcotic Anonymous", which is really made up of benevolent people. Oh, I do not know, but if that applies to the parole system, it probably would mean something.

The CHAIRMAN: Have honourable Senators any further questions to ask of the Chief Detective?

Senator LEGER: When your addicts come out of prison, is there anybody to receive them, to try and prevent them going back on addiction?

Chief ALLAIN: I do not know of any such organization in Montreal.

Senator KING: Mr. Chairman, we are told that these addicts do a great deal of pilfering from stores, and petty thieving. May I ask Chief Detective Allain if it is his experience to arrest these people.

Chief ALLAIN: Oh yes, very often.

Senator KING: Not as addicts, but for thieving?

Chief ALLAIN: Although we know he is an addict, we cannot put a charge against him for drugs. I would have to arrest him on a charge of shoplifting, for instance.

Senator HODGES: Would these people come within the 100 addicts, or are they listed separately?

Chief ALLAIN: They are the ones who are at large.

Senator HODGES: If he happened to be a criminal addict, would you put him down as a "criminal addict" or as a "shoplifter".

Chief ALLAIN: As a shoplifter.

Senator HODGES: Then your figures would not be correct? You say you have 100 criminal addicts. My point is that one of them might—

Chief ALLAIN: It might be one of those, yes.

Senator HODGES: Would he be charged with shoplifting, for instance, or for drugs?

Chief ALLAIN: We might not be able to charge him with drugs.

Senator HODGES: Then your records might not be quite accurate? You might have more in your records for shoplifting?

Chief ALLAIN: That is right, with shoplifters whom we know to be addicts. If we arrest a shoplifter, who is a drug addict, they are counted in the 100.

The CHAIRMAN: You count them in?

Chief ALLAIN: Yes.

Mr. LIEFF: You know who they are?

Chief ALLAIN: Yes.

Mr. LIEFF: You have the data on them?

Chief ALLAIN: Of course we have.

The CHAIRMAN: Honourable Senators, are there any further questions to ask of this witness? (No response). If not, on behalf of the Committee I wish to thank you sincerely for coming here today, and for the information you have given to the Committee.

Chief of Detectives Allain retired.

The CHAIRMAN: Our next witness is Doctor A. M. MacLeod, a member of the Board of Directors of the John Howard Society of Montreal, whom I will ask to come forward.

Mr. LIEFF: Mr. Chairman, with your permission, Doctor MacLeod, is accompanied by Mr. Edward Shiner, Master of Social Work and Assistant Executive Director of the John Howard Society of Quebec.

Doctor A. M. MacLeod (Director, John Howard Society of Montreal).

The CHAIRMAN: Doctor MacLeod, will you proceed in your own way?

Doctor MACLEOD: Mr. Chairman and honourable Senators, as Mr. Lieff has told you, I am accompanied by Mr. Edward Shiner, Master of Social Work, and Assistant Executive Director of the John Howard Society of Quebec. We prepared this brief jointly, with the idea in mind of saving some time of the Committee, and with your permission, I will now read my portion of it, and Mr. Shiner will then follow me.

The CHAIRMAN: That is all right. Will you please proceed?

Mr. Chairman and honourable senators; on behalf of the John Howard Society of Quebec, Inc., I should like to take this opportunity of thanking you for extending to us the privilege of appearing before this committee today. For purposes of the record perhaps I should make clear that the John Howard Society of Quebec is a voluntary Red Feather Agency, a member of the Welfare Federation of Montreal, and the Montreal Council of Social Agencies. Its prime concern is the promotion by all lawful means of the welfare of adult offenders and their dependents and with the examination and promotion of penal reform in accordance with modern principles of penology. As a Society much of our work is in the area of rehabilitation of adult offenders, and we are being continually challenged by the unusually difficult problems surrounding attempts at rehabilitating convicted drug addicts who have served their sentences. In the hope that our experiences may help the committee in their study of drug addiction among criminal addicts, we have brought together such data as we have on the drug addicts who have approached us for assistance during the past two years. Although we are fully aware of the importance of such broader aspects of the problem as drug trafficking, whether or not incarceration with or without treatment should be the method of choice or whether addicts should be given ambulatory treatment and a maintenance dose we feel we are most qualified to speak on the post institutional release aspect and would like to direct our remarks mainly to this area.

If we have your permission to do so, Mr. Chairman, we should like to present our brief in two parts. Mr. Edward Shiner, Master of Social Work, Assistant Executive Director of the John Howard Society of Quebec, will

deal specifically with the work of the Agency. Afterwards I should like to say a few words about our plans for an extension of our present rehabilitation programme in this area. Following this, if you think it worthwhile, I shall do my best to answer any questions members of the committee may wish to ask concerning my personal experience of the treatment of drug addicts while I was in medical practice in Great Britain. Naturally the opinions I express will be my own and not necessarily shared by others in the profession. My sole object in suggesting this procedure for your consideration is to have the committee's valuable time, and to do away with need for two completely separate presentations. Although I am appearing before you today as a delegated member of the Board of Directors of the John Howard Society of Quebec, I have also been invited to appear before you in an individual capacity by Mr. John A. Hinds, Assistant Chief Clerk of Committees.

Since 1938 I have been concerned with the treatment of individuals suffering from psychiatric illness. Most of my experience of the treatment of drug addicts was gained while I was assistant director of an in-patient psychiatric unit attached to one of the teaching hospitals of London University. The majority of the cases under my care were professional people, mainly doctors, although the list included nurses and non-professional people as well. Some of the patients were under voluntary treatment and some as a result of court probation order. I was also fortunate in being able to call on members of the Dangerous Drugs Inspectorate of the Home office for help and advice. Perhaps I should take this opportunity of stating that no matter how lenient the recommendations of the departmental committee (1924) on morphine and heroin addiction might appear on paper, in actual practice, in my time, all members of the inspectorate staff were strongly opposed to any line of action that would allow a known addict to continue his addiction with the help of a doctor who was willing to attempt to keep the addict on a minimum maintenance dose. I use the word "attempt" advisedly as I never discovered a case in which this method proved successful. This is not to be wondered at when one takes into consideration that nearly all persons who become addicted have clearly recognizable psychological disturbances to start with, coupled with the fact that toleration of the drug soon develops and requires an ever-increasing dose for temporary relief from psychic distress.

In some ways the characteristics of the patients I saw differed from those who make up the majority of the Canadian statistics. They were either themselves comfortably off financially or had a family or relatives from whom they could borrow. In no case was there any attempt to obtain supplies on the illicit market, even after their permission to prescribe drugs had been withdrawn, after conviction by the special medical tribunal, set up under the Dangerous Drugs Regulations. In many cases although the patient presented himself voluntarily for treatment, subsequent investigation proved that he knew the authorities were close on his heels.

In most cases the patients received intensive psychotherapy as soon as possible after subsidence of the withdrawal symptoms. This enabled a close observation of the patient to be maintained not only during the time he was in the hospital but also during the attempts at his social rehabilitation. I am sorry to have to say that with the possible exception of one case, the results of treatment under what must be described as almost ideal medical conditions was uniformly bad. That this may have been in some measure due to inadequacies in my treatment technique I am only too willing to admit. However, other factors were operative as well and a discussion of these factors may be of some interest to the Committee. I must make it clear, however, that

what I have to say is based on my personal experience with some twelve cases directly under my care and my experience may in no way duplicate that of other practitioners.

In the first place the problem of drug addiction is a complex problem involving social, psychological, medical and legal aspects. The temporary separation of the addict from his drug of choice presents no unsurmountable medical problem, although the physicians' task can be greatly complicated by the absence of such measures as some form of legal restraint to ensure that the patient carries out the withdrawal treatment during which time his judgment concerning himself is far from valid.

The keeping of the addict away from a source of supply seems to be more a problem for legislation and police enforcement than for the doctor, for my experience has been that wherever a supply exists the confirmed addict will find his way to it. In Britain, as far as the morphine derivatives are concerned, the only supply open is in the majority of cases a legitimate supply controlled by a practicing physician in good standing. In Canada the problem of illicit supplies seems to loom much larger.

The cure of the personality defects existing before addiction in most drug addicts is, in my experience, not at all hopeful in one present state of medical knowledge.

The social rehabilitation of the temporarily-withdrawn addict presents almost impossible difficulties although here and there one comes across the odd case which provides a glimmer of hope. Some evidence has been given before the Committee, I believe, to the effect that the drug addict on a maintenance does is less of a danger to society than say an alcoholic and that there are no epidemiological problems related to this illness. This has not been my experience. Without exception every addict whom I had in treatment either attempted to give expression to or fought against a clearly recognized desire to involve non-addicts. Although it would be logical to assume that the reason for such proselytism is the desire to render surer a source of supply of the drug, it was my opinion that this activity was the outcome of much deeper psychological conflict, and indicated a perverse inner need of the addict to turn his self-destructive drives against those around him as well as against himself. Drug addicts are predominantly sociable people, and they cannot stand any degree of social isolation for very long without attempting to find a suitable companion. As a matter of medical interest, I found this desire to make converts much more pronounced in the male addicts than in the female addicts. It is my belief that drug addiction has many features of an infectious disease. This is more clearly seen of course in the case of chronic alcoholism and barbiturate addiction but the present observation that new addicts are not being sought by the drug peddler is probably more an indication of the stepped-up efficiency of the enforcement officers, than it is of the tendency of the demand for narcotics to reach a stable level.

Nevertheless, despite these complicating factors, drug addiction is a community illness must be tackled constructively and realistically. If the problem has many facets such as the social and legal aspects as well as the medical and psychological, that is all the more reason for attempting to develop a constructive program in any of these areas which is open.

To begin with the problem must be recognized as affecting the whole community. The public must be educated to recognize its present inadequacies for the treatment of this serious illness. In the light of our present knowledge there is little evidence to support attempts at ambulatory treatment on an out-patient basis for the confirmed addict, and arguments in favour of the establishment of narcotic clinics where registered users could receive their minimum required dosage of the drug, can only be put forward by those with

little experience in this field as there is no scientific basis for the proposal whatsoever. Drug addiction leads to a remarkably unstable physiological state, and increasing toleration of the drug calls for increasing dosage.

The confirmed drug addict has an illness which involves the loss of power of self-control and his treatment requires some means whereby he can be legally detained for the period during which his judgment concerning himself is not valid. Moreover, his treatment must advance equally in the field of social readaption as in the field of personal psychological insight.

This brings us to a consideration of the nature and location of the residential institution and the various ways in which the confirmed addict can be kept under protective control while his treatment is being carried out.

I understand there has been no serious suggestion put before the Committee that any of the present penal institutions in Canada could function in any way, as an adequate treatment centre for drug addicts. Perhaps "institution" is the wrong word to use as it fails to convey the importance of setting up a practice social field in which the recovering addict could begin learning or relearning the necessary social skills and sets of values that are demanded of the healthy citizen. To set up such a colony would require not only medical specialists but other workers in the allied social sciences as well. Mere contemplation of this problem, both in the field of drug addiction and in the field of adult rehabilitation after release from prison sentence, points up the very real need to encourage in every way possible the recruitment and training of many additional skilled social workers interested in this after-care area.

Therefore, geographical location of such an institution is of much less importance than is its development as a community, isolated if need be, in which not only the physical and medical needs of the confirmed addict are met but also the psychological and social needs as well. In this respect many of the recent advances in the planning of residential treatment programs for juvenile delinquents, and the planning of long-term residential therapy for the chronic unemployable, are worthy of consideration. The training program for delinquent boys at Boscoville locally and the program carried out by Dr. Maxwell Jones in England in the field of the chronic adult unemployable, have many practical features that are likely to prove of value if a settlement devoted to the management of such knotty social problems as the case of the chronic drug addict and the care of the chronic sexual psychopath is ever set up.

As the treatment of chronic drug addiction on a purely voluntary basis has met with little success wherever it has been tried, means must be found to ensure that the patient will not terminate his treatment or rehabilitation before those in charge of his case consider his improvement to be such that he is ready for greater freedom of movement among the public.

Commitment by the courts is necessary in many instances but the length of this commitment should not be for a definite period. The concept of "the indeterminate sentence" needs to be translated into medical terms so that the length of commitment (i.e. treatment) would be determined by competent medical authorities. There should also be some provision for the addict who wished to enter the institution as a voluntary patient. This would involve the providing, by legislation if necessary, means whereby the patient could ask for commitment for a definite minimum period agreed upon between himself and the medical authorities. During this minimum period, discharge could only take place with the consent of the institutional medical authorities.

It must be realized that in all likelihood some of the present-day chronic addicts committed on such a basis would fail to show evidence of sufficient improvement to justify the recommendation that they could manage on their

own, while all of those passed on to the next stage of rehabilitation would require most skilled probationary supervision for many years. The relapse rate may be high.

As Dr. C. A. Roberts has pointed out, there are indications that it is possible to go a long way towards solving the problem of narcotics addiction if medical, social and rehabilitation methods are applied in a co-ordinated way. However, from what has been said up to now, it is clear, I think, that it will be a long time before any adequate comprehensive plan can be worked out. What, then, of the immediate handling of the ever-present problem of the released criminal addict? It in no way implies a failure to recognize the magnitude of the many still unsolved legal and medical difficulties if the John Howard Society of Quebec has decided to attempt to improve the situation in the only way it can within its own area of competence.

Primarily, the John Howard Society is a community agency and it is to the community that it has turned to in order to develop a beginning programme of rehabilitation of the released criminal addict.

Central to any programme of rehabilitation is the practical issue that, as far as Canada is concerned, the present method of addiction management is by and large incarceration and re-incarceration in a prison. For a variety of reasons it has been impossible to offer any adequate treatment beyond this measure. The John Howard Society recognizes that repeated imprisonment is ineffective in curing the addict, it is also expensive beyond all proportion to the results. No matter how valuable it may be as a temporary expedient, sterile social isolation of disturbed citizens is something that can never be encouraged as a long term policy. The history of the mental hygiene movement and the handling of the problems connected with chronic alcoholism, clearly show that no real progress can be made until the blind rejecting attitude of the community is broken down and replaced by the recognition that the problem of any one member is a common problem for the whole community.

It must be made possible for the drug addict to begin to hold his head up and to experience the willingness of other people to help him rid himself of his affliction. Before this can be done the desire for reform must come from within the addict himself; it can never be imposed from without. In many ways the treatment and social rehabilitation of confirmed drug addicts at this time presents problems similar to those encountered in the treatment of chronic alcoholism before Alcoholics Anonymous came into being. There is at the moment a small group of sincere drug addicts organized to encourage the kind of self-help in the field of narcotic addiction that is found in the shape of Alcoholics Anonymous, in the field of alcoholism.

The John Howard Society of Quebec feels that Narcotics Anonymous offers one of the most hopeful practical solutions in this area today. It sees in it the seeds of a powerful socializing force which can do much to bridge the gap between institution and community, if it is made possible for the addict to develop the inner strength and desire to follow this course. The United States, as far as we have been able to determine, has around 500 Narcotics Anonymous members, who are successfully following this self-help programme.

The Society wishes to do all it can to foster the development of a strong Narcotics Anonymous group in Quebec. The first concrete step has been taken with the creation of a small sub-committee of the John Howard Board. This advisory panel of citizens intends to enlist the aid of all other interested community members and community agencies where necessary and do all it can to educate both the drug addict and the healthy members of the community to the realities of drug addiction and the ways in which the problems of rehabilitation can be lessened.

To facilitate the work of Narcotics Anonymous in contacting potential members, representation has been made to the Penitentiary Commission to allow suitable Narcotics Anonymous members to visit addicts serving sentences in St. Vincent de Paul Penitentiary. Permission has now been granted for such a liaison between the prison and Narcotics Anonymous, and the John Howard Society looks forward to strengthening this one area within its own field of competence in the hope that it will encourage others in the community who have similar responsibilities in adjacent areas to initiate, where they can, other aspects of the total community on the drug addiction problem on the drug addict. The ultimate co-ordination of such efforts should do much to take the stigma out of this social disease.

The CHAIRMAN: Do you want to answer questions now, Doctor McLeod, or wait until Mr. Shiner has completed his presentation?

Doctor MACLEOD: Whichever you prefer.

The CHAIRMAN: I think it might be as well if you are questioned now, because there may be another part dealt with in the second part of the brief.

Senator STAMBAUGH: Has the Narcotic Anonymous in Quebec ever succeeded in effecting a cure?

Doctor MACLEOD: I would say to use the word "cure" in such a case as drug addiction, has to be used with caution. I would say it definitely, that for the present, the number of flare-ups of individuals in this organization, as far as I can make out, have provided a great strengthening in the psychological make-up of persons, than any other way of which I know. I would say it would be wrong to be too hopeful at this stage, but when we consider the early stages of the Alcoholic Anonymous, I would say there is very definite hope and promise, as this organization grows in strength.

Senator STAMBAUGH: Do you think it is as good as Alcoholic Anonymous was, at the same stage?

Doctor MACLEOD: No, but in regard to the problem of alcohol, there was found that in Alcoholic Anonymous, there were a large number in the various branches, and some could drop away, and there were always some others available in every situation to assist them back and to help them get away from their addiction, and endeavour to cure them, and, as I say, there were a number who could keep up the work.

Senator STAMBAUGH: The 500 you mentioned as being in the United States show that it has helped considerably.

Doctor MACLEOD: They can keep the situation under control for a longer time than any other treatment of which I know at the moment.

Senator LEGER: Do you know of any real cure in Montreal?

Doctor MACLEOD: If I use the word "cure" in that particular sense, I know of two addicts here who have not taken up drugs again.

Senator LEGER: In how long?

Doctor MACLEOD: I would say about three and one half years, while in Britain they have been under treatment for a considerable length of time.

Senator LEGER: How many did you have?

Doctor MACLEOD: Only two in Canada, who remained free.

Senator LEGER: And how many cases have you treated?

Doctor MACLEOD: In Canada?

Senator LEGER: Yes.

Doctor MACLEOD: None. All I treated were in Britain. There is the John Howard Society or its equivalent in each province.

The CHAIRMAN: Would you elaborate on the British system? When we were in Vancouver, we found some psychiatrists were "sold" on the idea that

if we had the British system in this country, we would not have the drug problem such as they have in Vancouver.

They gave us the idea that in Great Britain they supply some narcotics free.

Doctor MACLEOD: There is no justification at all for suggesting that Britain allows drugs to be given for the maintenance of their addiction.

The way the law reads, theoretically it would be possible for a doctor to diagnose a man's illness as being, for instance, morphine poisoning, and treat him, but he would recognize that by giving the drug, he would be writing out the prescriptions himself.

In Britain, that has never been done, and he would be brought up before the Medical Council very quickly if he ever did such a thing.

So I think it is unfair to suggest there ever was this method of handling drug addiction in Britain.

The CHAIRMAN: They mentioned 305 out of a population of 45 million, and the figure is so small, that we begin to wonder—

Doctor MACLEOD: I think they gave the figure of the ones which they knew. My impression—and it is only an impression—is that most drug addicts—and I am speaking of heroin and morphine, and not marihuana—come under the notice of the authorities very quickly. I am thinking of doctors who use their licence to prescribe, and who are anxious to get hold of the addicts, and they manage to get in a supply other than their actual requirements, and who purchase the supplies of other doctors, and then treat them in the usual way. It may be that reference was being made to the present system in Britain, but no indication was given of what the figures may be, and it may be that such illnesses fall off very quickly.

The CHAIRMAN: We have been informed there are no criminal addicts such as we have in Canada. In Canada, the figure given us was about "50" or "60". But in Britain we were told they have a system by which they are getting it from the doctors.

Doctor MACLEOD: I would like to make a distinction between "morphine", "heroin" and "marihuana", and with reference to marihuana, I have no knowledge that it is being used extensively.

Senator STAMBAUGH: I would like to ask a question regarding Great Britain. Suppose a doctor in Great Britain gives a prescription to another person for four capsules a day for a period of time; would he "get away with it"?

Doctor MACLEOD: No, I do not think he would.

Senator STAMBAUGH: What would happen?

Doctor MACLEOD: Theoretically, it is possible. If he was treating a man for an illness which has no connection with the psychological aspect, he can give drugs to ease a man's pain. But the psychological problem is such that the doctors get rid of the addicts, even for another doctor, because they are asking constantly for something to increase the doses of morphine, and come in at odd times, and demand that you stop what you are doing and give it to them, and they ask for barbiturates to keep them going.

The addict is always fearful of the supply of drugs being lessened, and he will go to the ones who he thinks can supply it.

When dealing with peddlers, the addicts know they can only get a small supply, but if they can go to a doctor, they can get as much as they feel they want.

So the man would be recognized as an addict by the other doctors, and I think it is fair enough to say that there is a special standard of ethics in Britain, which would make the doctor tell the addict he would not give him any more, and if he was pressed unduly, he would report it to the Medical Board.

The CHAIRMAN: Do you say they get a supply outside the doctors?

Doctor MACLEOD: I have not seen that happen. But I have seen a doctor, after losing a certain amount of his practice, take a position in some place where there is a shortage of doctors, such as mental hospitals, and he will sometimes rob the drug cupboards, or something of that nature, but I never knew them to obtain drugs illicitly by other methods.

Senator GERSHAW: You have treated a number of cases; can you tell us how long it would take for the withdrawal symptoms to subside? How long would it take to get it out of their system?

Doctor MACLEOD: That is complicated by psychological factors. I will give you an example. There is one case, whom I would like to regard as a cure, which was that of a doctor of about 50. About the time I met him, he had become a morphine addict. He had an operation at that time, and a number of subsequent operations, and required sedation of a substantial nature, and he became a "dope" addict.

He then had a final operation by another surgeon who cleared up the whole condition, and he put himself off the drug by his own efforts, and he was off of it for about fifteen years. I do not want to give too much identification, but he became a doctor with the Services during the war, and as a result of coastal action, he was thrown into the waters, and was captured by the Germans, and he specifically asked that he be given no morphine, but it was given to him, nevertheless, and he finally found himself on the drug again.

He had two children in school, and came from a university town, but he sold his practice and came down to London for hospitalization. The police were not after him, and nobody knew anything about him, and he made no demands in his withdrawal period. He had no withdrawal symptoms for the first two nights, but, answering your question, I think it required about ten days by the old method, but I think nowadays—

Senator GERSHAW: They use the demerol?

Doctor MACLEOD: Now they use one of the new drugs, chlorpromazine, or what is commonly known as "largactil", which has only recently come into the market.

Senator GERSHAW: Then, for what time was he under psychiatric treatment?

Doctor MACLEOD: I would not like my figure to appear extreme, and I would like to modify it by saying there is a difference between the former addicts and the new addicts. The former criminal addicts, I would say, would require at least five years' detention. I do not mean there is anything to be gained by putting a man in a strait-jacket, or an isolation ward, as he will be the same when he comes out as when he went in. What I think we should do is to put them in with other people, where they will learn social skills, and good citizenship, but very few of our institutions have reached that stage.

Senator GERSHAW: Supposing an institution could be found which would do that; would that in six or eight or ten months get a man away from the morphine?

Doctor MACLEOD: No. I would like to look at it this way, that the taking of the drug is evidence—even in the psychosomatic treatment, that no matter how long you keep him off the drug, the effect will not last very long. The individual can withstand his psychological need for the drug when in a very strict world around him, and he has to fit into it, but when you put him into a free world again, he comes in conflict with other beings, and when he does, he will almost invariably start taking drugs again.

So I do not think we can think of them like one suffering from, say, tuberculosis, where with two years in a sanatorium, the chest lesions will disappear, and the man can be allowed out again.

Senator GERSHAW: What type of treatment would you say would cure a fair percentage? You give him hospital treatment and rehabilitation. Then, what next?

Doctor MACLEOD: I think there are some, as far as I can judge, would never get to that stage of development. Now and then we might find groups which would. I would say they should be out on some form of probation or treatment, which would enable them to move about in the community, and come in contact with a group, such as the Narcotic Anonymous, who would keep in touch with the Probation Officers in an endeavour to strengthen a man's character to the point where he can carry on.

You cannot give an answer to that question, except in terms of a person on probation. He himself needs the human relationship, and any attempt at rehabilitation by imprisonment is of very little use.

Senator LEGER: You would say that while on probation, he should mingle with other people?

Doctor MACLEOD: Very definitely.

Senator GERSHAW: You feel there is a certain time when nothing can be done?

Doctor MACLEOD: I would not say "nothing". I would endeavour to see that they do the things they can do, but they should not be confined. What they need is treatment for an illness. I think each individual would be helped tremendously if we could provide a quarantine area for them—and I use the word "quarantine" advisedly. I think they could lead very useful lives in a quarantine area, if we could provide the necessary facilities, and we could then provide something reasonably close to the Alcoholic Anonymous. They are treated—that is, the Alcoholics—as human beings, and come in contact with other people.

I will say that there were many chronic alcoholics before Alcoholic Anonymous came into being which created a terrific problem, and at that time, I think I would have said the same as I am saying now for the Narcotic Anonymous.

While Alcoholic Anonymous is by no means an ideal solution, I am sure many people now feel that it has made very great advances.

If we could get together a group of people to take care of these addicts, it would be a great service.

Senator BEAUBIEN: That was stated here by the addicts themselves.

Doctor MACLEOD: Yes.

Senator HODGES: Would you say that addicts create other addicts?

Doctor MACLEOD: Yes, that has been my experience.

Senator HODGES: Is it your experience that some addicts start out simply out of curiosity?

Doctor MACLEOD: No. I agree with some of the other doctors, that some of them are born looking for drugs, and if you took youngsters and followed them all through their growth, you would find them developing the habit at very early years.

The CHAIRMAN: It would make our task very difficult, if many of them were born with that tendency.

Doctor MACLEOD: My experience has been that that type is very difficult to clear up.

Senator HODGES: Do you find that some of the addicts had delinquent tendencies before becoming addicts?

Doctor MACLEOD: That is a difficult question to answer. The word "delinquent" covers such a wide field of human behaviour.

Senator HODGES: A good many people who have appeared before us have stated that a majority of the addicts were criminals before they became addicts.

Doctor MACLEOD: I would like to wait until my colleague, Mr. Shiner, gives a statement on the Montreal situation.

Senator KINLEY: But the criminal is more apt to become an addict?

Doctor MACLEOD: I think we have gained considerable knowledge in our medical practices. But before that time, there were many things we could do very little about, and which were very painful. Very often, there was nothing we could do but give a person the drug. Even today, if you have an incurable case of cancer with great pain, I think any doctor would feel justified in putting such a person on a pain-relieving drug.

Senator BEAUBIEN: You are acquainted with the Lexington situation?

Doctor MACLEOD: I know of it.

Senator BEAUBIEN: You know the work they are doing?

Doctor MACLEOD: Yes.

Senator BEAUBIEN: Would you favour such an institution in Canada?

Doctor MACLEOD: Yes, but I would like to add that drug addiction should be viewed in two ways.

I agree with the Superintendent of the Royal Canadian Mounted Police, that it is, by far, the easiest way to put a stop to much of the trafficking.

The drug traffickers are known in a community, and I think by a concentrated effort on the part of the police, they would be able, by helping each other, to pin-point the majority of the criminal addicts. If you took them out of the environment of the quarantine area, you would have to deal only with the general addicts. They are easier to cure. Those are the cases which would benefit from an institution like Lexington.

I think the criminal addicts require more treatment than psychological and psychiatric help. They need socialization, which is not given in any place, anyway.

The CHAIRMAN: Honourable Senators, have you any further questions to ask of Doctor MacLeod?

If not, our next witness will be Mr. Edward Shiner, Assistant Executive Director of the John Howard Society of Quebec, Incorporated.

I will ask Mr. Shiner to come forward at this time.

Mr. Edward SHINER (*Master of Social Work—McGill, and Assistant Executive Director, John Howard Society of Quebec, Incorporated*).

The CHAIRMAN: Will you proceed, Mr. Shiner?

Mr. SHINER: I find myself in the position of presenting a summary of the contacts which we, as an agency, have had with drug addicts during the last two years, and with your permission, sir, I will read a report of our findings.

Mr. Chairman: For a considerable time medical science has accepted the fact that drug addiction is a very serious and regrettable condition. Doctors also see addiction as being symptomatic of underlying emotional upheaval. However, the public still views it as an abhorrent crime, and the term "dope fiend" is still in common use. The desirable goal of lasting cure for addiction is negatively affected by this uninformed attitude of the communities to which the addict returns upon release from prison.

Data on our Drug Addict Clients:

The John Howard Society of Quebec offers an after-care service to the non-Catholic population of Montreal. From this grouping, 19 admitted drug addicts applied to us for rehabilitative assistance. Thirteen were male, six female. Their ages ranged from 27 years to 55 years, with most in the age grouping of 40-49 years. A grade school education was most common (8) while six had high school and four university training. Three men had never been employed in legitimate work. Five other men were labourers, one a skilled tradesman, two clerical and two professional. Among the female addicts three had carried domestic work only, while the other three were in the clerical field. With all nineteen their work record was irregular to the extent of being almost non-existent.

Of our nineteen clients, sixteen had not been convicted of a criminal offence prior to their becoming addicted. Two had technical offences such as "disturbing the peace", and only one, from our information, had a conviction for a criminal offence as a juvenile. This evidence, although the number in our group is small, tends to go contrary to the West Coast view that addicts are delinquents before becoming addicts.

All nineteen cases had convictions after becoming addicted. Taking eighteen of the clients into account, their conviction totalled 173. The average conviction was 9.6 with over half of the group having less than the average number of convictions. The nineteenth addict has had 29 convictions in the past five years and the criminal record dates back to 1923 with no appreciable change in the pattern of excessive delinquent behaviour.

The age upon which eighteen of these clients first became addicted to drugs shows, almost twice the number became habitués while under 24 years of age, in fact four were only age seventeen, and one woman fourteen years. Without exception, heroin was the narcotic used. However, six had their beginning experience with opium, marijuana or barbiturates.

Length of addiction could be determined for eighteen cases. Addiction length ranged from six months to thirty-three years. The average term was seventeen years. This small sample of eighteen had been addicted for a total of 306.5 years.

Only three have been able to secure voluntary hospital treatment for their addiction. All treatment plans were unsuccessful. One man, after two unsuccessful hospitalizations, achieved abstinence after joining Alcoholics Anonymous and later Narcotics Anonymous. He has been drug-free for three years. The usual pattern for our clients has been relapse to narcotics and further delinquency. Fifteen have followed this course. Outside of the one Narcotic Anonymous member previously mentioned, one has also been successful through Alcoholic Anonymous and Narcotic Anonymous for four years, one had not relapsed for four months following release from his first sentence and the fourth person returned to criminal activity while not using drugs, after six months of unsuccessful job hunting.

This picture would not be complete without reference to the family and marital background of these 19 people. Their current emotional instability has its roots in a depressing panorama of childhood maladjustments, unhappy homes, disintegrated families and unfortunate early work experiences. Fifteen had attempted marriage in some form or another and all unions, whether legal or not, were disrupted by divorce or separation.

Of the nineteen cases, we have judged that thirteen were strongly enough motivated towards changing their pattern of past behaviour to make a genuine effort to sever their contacts with the addict community. In general, they were ill-equipped to face the realities of their proposed plans and with no treatment resources geared to their needs they relapsed after varying periods of abstinence. The exceptions have been noted.

These data on the narcotic addict group with whom we have had contact during the last two years reveal a fairly representative sample of Canada's addict population as reported in the available related literature. It is recognized that the older user, fully cognizant of the pitfalls of addiction, is the one who most usually seeks help and yet the damaging psychological effects of narcotic habituation have had their greatest influence upon such persons. In addition, the social isolation from normal living becomes more pronounced, and returning to the community becomes increasingly difficult. The vicious circle of addiction, imprisonment, release, repeated over and over is all too apparent in our sample. The early age of first addiction surely calls for rehabilitative attempts to be made at this stage before permanent psychological and social damage results.

Beyond the incalculable human misery found in addiction, there is the startling thought of the cost to the Canadian community. If it can be assumed that three quarters of the period of addiction of our clients is spent in prison and if one half of the time that they are free is taken up with the use of drugs, then using a conservative cost figure of \$20 a day for their narcotic expenses will lead us to conclude that these seventeen addicts have spent over \$250,000 on their drug supply during their years of addiction. This sum did not move through normal monetary channels. This figure does not take into account concomitant expenses—the cost of incarceration, the loss of potential wage earners who contribute to the nation, or the discrepancy between the retail price of the goods stolen and the amount paid the addict by the receiver.

There is ample evidence in this shocking picture from our own regional experience to demonstrate the need for such comprehensive study of the problem as this Committee is undertaking.

The CHAIRMAN: What would that addict do, to get thirty-two years? That is about as long a sentence as we have heard so far.

Mr. SHINER: I believe you somehow got mixed up in the figure. That was the length of his addiction.

The CHAIRMAN: Oh yes; I stand corrected.

Senator HORNER: Are you able to meet all the addicts who are let out of prison, or only those who express a desire to have you meet them?

Mr. SHINER: We are a voluntary agency. We cannot impose our services on anybody, unless it is through what we term "ticket of leave" with the co-operation of the Remission Service, or through the courts by way of suspended sentences.

There is a definite rule of no interference with the rules of the Remission Service, and the courts are certainly in no position to recommend the use of the John Howard Society for the supervision of drug addicts. I think in that way our experience has been too negative.

Senator HORNER: Do you visit the jails?

Mr. SHINER: We visit the two Federal Institutions, and the jails. We contact those who express a desire to see us, or who have been referred to us by somebody in the institution.

Senator HORNER: If they express a desire for you to see them upon release, do you make it a point of meeting them?

Mr. SHINER: We do see them prior to their release. We have the privilege of visiting them for three months before release. In St. Vincent de Paul, we can make contact at any time during their sentences—

Senator HODGES: If they ask for you?

Mr. SHINER: Yes. In some cases, there have been referrals by some official of the institution.

I think you can see we have not had the degree of success we would have liked, but, to use Doctor McLeod's words, there are "glimmerings of hope".

We are still prepared to offer our services. We realize the incompleteness of the services we have been offering to reach the addicts, and, consequently, we have turned our interest to the community programme, and we have brought our programme forward for community education, and to arouse the interest of the community to support the Narcotic Anonymous group.

Senator HORNER: Do you endeavour to cure them as a part of your work? I think that would be a great necessity for them.

Mr. SHINER: Our programme of rehabilitation is geared around such concrete things as financial assistance, regarding places to stay, and regarding their food, maintenance and clothing. These are some of the things we may pass on to the Public Health. We offer a service to try and help the persons to reach a point where they will accept responsibility. That is the kind of service of which Doctor McLeod spoke, that is, of creating in a person a sense of responsibility in his relationships with others.

We have had considerable success with the other groups of release inmates, but with the drug addicts, we have to first reach them. Our lack of contact through the period of addiction seems to limit the help we are able to offer them on the question of relationships, which would take a longer time than the voluntary basis on which we work would allow.

The CHAIRMAN: What do you find is the attitude of the employers of labour toward an addict?

Mr. SHINER: Extremely negative, on the whole. As a matter of fact, we find the whole community is negative toward released inmates. We have a plan to develop employment contacts. We have had some success, but there is much yet to be done in that respect.

We think we should be frank with a prospective employer, and say, "We have a man who has a certain background; we want you to fully recognize that as an employer. We have confidence this man could contribute something of importance to you".

We have not had the full confidence of the drug addict group. The prospective employers feel that an addict may hurt them by stealing from them, and they "shy away" from them.

The addicts' ties are not strong enough, and we cannot hold them together in many cases.

The CHAIRMAN: If society will not accept the drug addicts, it will make the task of this Committee more difficult when making our recommendations. That is why I asked the question.

Mr. LIEFF: Is it fair to say that having in mind the very difficult times you have had with them, you are prepared to put the support of your organization behind Narcotics Anonymous, and keep trying to work in that direction?

Mr. SHINER: That is our plan. But we will continue to contact them on an individual basis. We feel we will have something to offer a person who is making the attempt, regardless of how feeble it is.

Mr. LIEFF: But you think you must have more than your own programme, as far as you are concerned?

Mr. SHINER: Yes.

Senator STAMBAUGH: Are you able to give any further service to the addict than to any other person released from prison?

Mr. SHINER: It may be a little more explicit. Have you something in mind, Senator?

Senator STAMBAUGH: The John Howard Society will meet anybody coming out of prison and help them in regard to rehabilitation?

Mr. SHINER: Yes.

Senator STAMBAUGH: Do you offer any other services to the addicts?

Mr. SHINER: We have nothing to offer, apart from the psychiatric hospitalization. It is more of a pilot experiment, and to some extent unsuccessful, I must admit.

I am a little at a loss as to how to communicate the idea I would like to put before you.

The concrete services we offer, for instance, are the assistance to families, and in regard to food allowances and clothing. These are some of the things in connection with our work.

We can appreciate some of his background, even perhaps some of the difficulties he has had with his family, and we find out where he has broken down, and we will endeavour to help rehabilitate him, but that is a situation more or less in the future. Unless they have had the training necessary to get them through crisis without slipping back into their criminal attitude, or some other form of breakdown, it may be a little more difficult for them to take the next step. This requires a longer process, and in many cases we cannot hold on to our people as long as we would like to finish the job. This refers back to the statement by Doctor McLeod as regards the extensive time required to rehabilitate this addict group, if you are going to reach them at all, and offer them any assistance.

Senator STAMBAUGH: Still you offer this service to any other released prisoner?

Mr. SHINER: Yes.

Senator BIRCHILL: Has the Narcotic Anonymous made any inroads here?

Mr. SHINER: Yes. At the present time, there is a small group. At this moment, there are three people who have not been using it for six months up to four years.

Then there is the floating group which reached out to Narcotic Anonymous, tested its programme, found it unreliable, and left.

We have a floating group outside of the nucleus of three, of perhaps five or six, but they have difficulty in contacting the other addicts, because they realize the futility of approaching an addict when he is on the drug. They must work during the period of withdrawal, and, consequently, they try to help them get into institutions.

Senator BAIRD: It is your hope that it becomes as successful as Alcoholic Anonymous?

Doctor MACLEOD: You say it is a "hope". It is really health and social psychiatry, and you need at least 17 or 18 to form the type of group you want, because some of the individuals may feel it easier to take up some other problem. If you have a small number, it is not possible to keep all of the members active at the same time. I can remember in the early days of Alcoholic Anonymous in Britain, having a situation where there were just a few members involved, and if one of their number came back intoxicated, he might take away the whole Alcoholic Anonymous group with him, but where you have a group of 30 or 40, that condition is greatly improved.

The CHAIRMAN: Have honourable Senators any further questions to ask either Doctor MacLeod or Mr. Shiner? (No response.) If not, gentlemen, on behalf of the Committee, I wish to thank you very sincerely for coming here today, and for the very good information you have given us.

Doctor MacLeod and Mr. Shiner retired.

The CHAIRMAN: We will adjourn now until Monday morning at 10:30 o'clock.

The Committee adjourned until 10:30 a.m., Monday, May 30, 1955, to reconvene in the City of Ottawa.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

OTTAWA, Monday, May 30, 1955.

EVIDENCE

The Special Committee on the Narcotic Drug Traffic met this day at 10.30 a.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable senators, we have a quorum and will commence our morning sitting. We will not have a long session this morning, and I think another meeting after this one may very well clear off the witnesses we have in mind.

We were going to have another witness from the Bureau of Statistics regarding the crime situation, and giving us figures, but he will not be here this morning.

As we have to put something in our report regarding penalties, I thought it advisable to call Mr. Varcoe, who will say something about the law, and how far we can go. He will be the only witness this morning.

Mr. LIEFF: With your permission, Mr. Chairman, may I say that Mr. Varcoe is the Deputy Minister of Justice.

The CHAIRMAN: I will ask Mr. Varcoe if he will now present his views to the committee.

F. P. VARCOE, *Deputy Minister of Justice*: Thank you, Mr. Chairman.

Mr. LIEFF: Mr. Varcoe, during the hearings of this committee, we have heard various recommendations from time to time, urging the establishment of suitable treatment facilities for the addicts, and one of the suggestions deals with the establishment of a central institution. That raises the question of the committal of addicts and their legal detention for as long a time as they are required to ensure successful treatment.

There seems to be three classes of persons involved. Firstly; that of the drug addicts serving sentences in federal penitentiaries. The second category is the drug addicts serving sentences in the provincial jails; and, thirdly, the drug addicts at large, who are not facing prosecutions of any kind, and are not before the courts.

With your permission, if we could take them in order, would there be any difficulty in the committing of addicts in category No. 1, that is, those who are serving sentences in the federal penitentiaries?

Mr. F. P. VARCOE: No. I think if suitable legislation were provided, provision could be made for committing a person who has been sentenced to a penitentiary term. Such a person could be committed to a central institution.

Senator HORNER: There would be some difficulty there, as to whether the crime he committed was purely the result of his drug addiction, or whether he was a criminal at heart.

Mr. VARCOE: I do not think there would be any difficulty about that. I am assuming, of course that treatment which would be given would not involve anything in the way of surgery, for example. It would mean he would be confined in a certain way, and required to observe a certain regime .

The CHAIRMAN: And do some work?

Mr. VARCOE: Yes.

Senator HORNER: It could very well be that it would be best just to leave some criminals in the penitentiaries. It would be too expensive a procedure, in any institution for the treatment of narcotics. They would be more of a hindrance or a stumbling block to proper reformation.

Mr. VARCOE: Yes, quite so. I thought you had in mind if an addict was convicted of a crime which did not involve addiction, or any narcotic offence, could he be committed to this institution?

Senator HORNER: Yes.

Mr. VARCOE: I think he could.

The CHAIRMAN: If it was known he was a drug addict.

Mr. VARCOE: Yes.

Senator HODGES: If we had a special institution?

Mr. VARCOE: Yes, of course.

Senator HORNER: That might be a question for the Department of Justice to decide, whether he was a safe person to release from the strict penitentiary rules and given a chance to reform in a narcotic institution.

Mr. VARCOE: Yes, that is quite correct.

Mr. LIEFF: The next category, Mr. Varcoe, is in regard to drug addicts serving sentences in provincial jails. Does that give you more difficulty?

Mr. VARCOE: I had come to the conclusion previously, in discussing this matter with the Health Department officials, that the Criminal Code could be amended in such a way that even persons convicted of offences in a province other than where the central institution is located, could, nevertheless, be transferred to a central institution, such as the one of which you are speaking.

Mr. LIEFF: You say "committed a crime"; you mean within the meaning of the Criminal Code?

Mr. VARCOE: Yes. If he was convicted of an offence under a provincial law, I do not think that would be sufficient to give us jurisdiction over him.

Senator HORNER: Would it be better, instead of having one central institution, to have several provincial institutions?

Mr. VARCOE: In discussing that matter with the officials of the department some months ago, that question was raised, and it seemed, having regard to the number of addicts in the country, that the expense of setting up such a central institution would be about all we could afford. That was the impression I gathered.

Senator HODGES: In the provinces where the narcotic problem is the greatest?

Mr. VARCOE: My information was—and I am sure the committee knows more about it than I do—that the problem exists mainly in Ontario, British Columbia and Quebec.

Senator HODGES: From what we have heard, it may be that by clearing up the trouble in those three provinces, you might simply send them to some other provinces.

Mr. VARCOE: Yes, that is so.

Senator STAMBAUGH: With 3,000 addicts in Canada, there would be some difficulty.

Senator HORNER: You will find them scattered throughout the whole of Canada. That is the alarming situation.

Mr. VARCOE: The legal problem, as far as we are concerned, consist chiefly of the third class, that is, people known to be addicts, but not charged with any offence.

Senator STAMBAUGH: With any criminal offence?

Mr. VARCOE: Yes.

Senator HORNER: That is the great question as I see it.

We were amazed when in Vancouver to learn of the number of who are not prosecuted, but they are walking the streets and are well known to the police as addicts and criminals. The police expressed great difficulty in actually catching these people in making a sale, or with drugs on their persons. The police mentioned the many devices used by them for hiding this addiction.

There, the suggestion was made that the Criminal Code could be amended so that it would be an indictable offence to be an addict. While there might be some opposition to that, it seems to me there might be some leeway given, perhaps to doctors, or some tapering-off period provided to give them a chance; but I would hesitate to accept a job as a policeman and be in the position where I could see them walking all around me and have no power to arrest.

Mr. VARCOE: That is right.

Senator HORNER: From the evidence we think the addicts would soon become known, and the addiction would be verified, because if the drug was taken away from them they would soon exhibit the withdrawal symptoms.

Mr. VARCOE: The only way I think that could be dealt with, would be to provide that if a court was satisfied on the evidence that the individual was addicted he could be confined, but I do not know how you would get that evidence, I am sure. I do not know what kind of evidence would be produced—

Senator HORNER: The police think if they arrest a man, and they see the marks in his arms, or if he becomes ill, they know he is an addict, but under the present system, they cannot hold that person.

Mr. VARCOE: The only legal way to do it—and I do not think I would want to recommend it—would be if the evidence shows the man was addicted, that he had thus committed an offence.

Senator HORNER: And the signs would show that he had committed an offence?

Mr. VARCOE: Yes, but I do not know whether Parliament would approve of that.

Senator BAIRD: I do not see how we can do anything, unless the police have the power to pick up the suspects.

Mr. VARCOE: I did not recommend it to the Health Department, because I did not feel I was called upon to do so. But since you have been talking about it, it occurs to me that before that proposed evidence, such as the honourable senator suggests, could be taken under the law as proving the commission of an offence for which he could then be convicted, it would have to be different from simply saying that he can be confined because he is ill—

Senator HORNER: He would have to offer proof he is suffering from some physical illness which requires treatment.

Mr. LIEFF: I take it, with respect to category No. 2, that, providing they are serving sentences for federal offences—if I may put it that way—they could be committed?

Mr. VARCOE: I would think so.

Mr. LIEFF: Assuming the drug addicts—divorced of course, from possession or trafficking—is considered to be ill, could we properly legislate so as to make it a crime?

Mr. VARCOE: We have just discussed that. The amendment would have to be put in this form, that illnesses could be regarded as evidence of crimes, and the physical condition of a man might go to prove the commission of a previous offence.

Mr. LIEFF: Could we go this far? If we picked up an individual, and it is disclosed or suggested that he is a drug addict, could we bring him before some tribunal to explain his condition? Could we put the addict or trafficker in a position where he could come before some tribunal, and be put under oath to explain his conduct, whether he is an addict, and what he has been doing under certain circumstances.

Mr. VARCOE: I do not quite understand you, Mr. Lieff.

Mr. LIEFF: With the difficulty in securing proof particularly in trafficking cases—as is known, sometimes we cannot get the evidence—

Mr. VARCOE: It is not trafficking you are interested in right now?

Mr. LIEFF: This is going a step further. As it is now, these men just do not go into the witness box, and we cannot question them. But if we have knowledge of some contact with dealers or “pushers”, could we put them in the position whereby they would be called upon to be questioned under oath?

Mr. VARCOE: You would have to charge them with some offence.

The CHAIRMAN: Could they be arrested on suspicion, and forced to go into the witness box?

Mr. VARCOE: If the suspicion is well founded. However, I think the police officer would be running the risk of being charged with making a false arrest.

The CHAIRMAN: If a man is hanging around a bank at night, he can be arrested on suspicion of theft.

Mr. VARCOE: Yes.

The CHAIRMAN: Then why not arrest a man suspected of trafficking?

Mr. VARCOE: Mr. Lieff was speaking about drug addicts, not traffickers.

Senator HORNER: If you made taking a drug an indictable offence, then what about the conspiracy angle entering into it, that a man intended to buy illicitly?

Mr. VARCOE: You have the traffickers in mind?

Senator HORNER: Yes, or even the addicts whom the police are satisfied are buying on the illicit market. You have conspiracy there.

The CHAIRMAN: To get a proper opinion from Mr. Varcoe, we have to get this into a proper perspective, and not jump from addicts to “pushers”. If we get only one thing before him, Mr. Varcoe can probably give an intelligent answer.

Mr. LIEFF: We have an addict who is getting his drugs from somebody, and we know or suspect he is an addict, and the thought is we might develop some procedure whereby the addict would be forced to go into the witness box, and give some explanation of his contacts with the traffic.

The CHAIRMAN: To prove he was not an addict?

Mr. VARCOE: You mean to charge him with some offence, and then require him to convict himself? I think you might have a hard time getting that through.

Mr. LIEFF: It may go that far.

Mr. VARCOE: It would be bad enough to examine a man's body, and have him convicted on that evidence. There will be objections to that, I can tell you.

Senator BAIRD: All addicts should be registered.

Senator HODGES: Until they come within the purview of the law, how can that be done?

Mr. VARCOE: Such matters as registrations, fall into the provincial field.

Senator STAMBAUGH: They cannot force a man to go into the witness box.

Mr. VARCOE: Not under the present law. You cannot even put him in the box when he is charged with an offence.

Senator BEAUBIEN: You cannot force a man to testify against himself?

Mr. VARCOE: No.

The CHAIRMAN: How about allowing the judges to give maximum sentences? Do you think that would result in some judges being too lenient? I have always felt that judges faced with giving stiff sentences, are inclined to be somewhat lenient.

Mr. VARCOE: I think Mr. Hossick could tell you about that better than I.

Senator HODGES: You mean for possession of drugs, or just drug addicts?

The CHAIRMAN: Possession of a drug. I think five or ten years as a definite sentence would be a good thing. But, Mr. Varcoe, if we had a law of that kind, would the judges in Canada be very keen to hand out such sentences?

Senator STAMBAUGH: You mean just to make one sentence?

The CHAIRMAN: Yes. And to say "If you are in the trafficking, it is ten or fifteen or twenty years."

Mr. VARCOE: I do not think the experience of the department has been that there has been any difficulty in getting severe sentences imposed for drug offences. On the whole, I think the judges recognize the necessity for severe sentences.

Senator HORNER: It seems to me that something will have to be done in connection with drugs. Canada, right now, is in a position where we will have to take some action. We are faced with 150 addicts in the Oakalla jail, together with men who should be good citizens, and yet one young chap when asked how long he had been taking drugs, said "Only one year", but he said that was the life he wanted to lead, and he defied anybody to cure him.

When we think about countries such as Japan and England, surely this has gone beyond all reason. In other words, the business seems to be increasing.

The CHAIRMAN: One of the problems facing our committee is the fact that we see so many known drug addicts walking about loose, and as long as they are, the number of addicts is increasing. We are wondering what the best plan is for stopping it. If you cannot pick a man up on suspicion, you have to catch him, and that is one of the greatest difficulties. Very often the police would have to break into a home to catch him.

Mr. VARCOE: Are not most of those people in British Columbia?

Senator HODGES: Yes.

Mr. VARCOE: Why does not the provincial government take a hand? They could commit these people for treatment, without any offence being charged.

SENATOR HORNER: We have had addicts come before us with the argument that one addict does not create another—that is the addict's story—but I think the committee was convinced there was a great danger, particularly with young women and girls being induced into becoming addicts. In nearly every case addiction is the result of association with addicts; therefore, there is a great danger in leaving these addicts loose. They are certain to create associations, and so on.

I have asked all the medical men who came before us about the people who through serious accidents or illnesses needed the drug, and who acquired the habit, but no doctor admitted, that, except in very, very few instances, do they become addicts because of treatment.

It all boils down then to this, that these new addicts are being created by old addicts.

Senator BEAUBIEN: Your opinion, Mr. Varcoe, is that in British Columbia, where they have the greatest number of addicts, that the province could pass a law to bring these addicts before a court?

Mr. VARCOE: And have them committed, as in the case of Dr. Hollis.

Senator BAIRD: You think it is more a matter of provincial than federal responsibility?

Mr. VARCOE: I am speaking of people not charged with offences.

Senator HODGES: People who do not come under the Criminal Code?

Mr. VARCOE: Yes, that is right.

Senator STAMBAUGH: It would be better to have some law on that problem.

Mr. VARCOE: Oh, by far.

Senator HODGES: If you have most of the addicts in one province, it would not apply to the other provinces.

Senator STAMBAUGH: Not to the same degree.

Mr. LIEFF: Sir, would there be any objection to the provinces passing legislation that these addicts be committed to a central institution?

Mr. VARCOE: Well, the legal difficulty would be that the law of British Columbia, for example, would not operate in the province of Ontario.

Supposing British Columbia passed a law authorizing the committal of a British Columbia addict to an institution in Ontario, such a law could not operate.

Mr. LIEFF: Supposing we were to establish a central federal institution—a Lexington type of institution—established by a federal authority, would there be any objection to that?

Mr. VARCOE: I understand the Lexington system works in this way; that a person from some state other than Kentucky goes there voluntarily. I do not know how they get him there, but if he changes his mind—

Mr. LIEFF: Then he walks out. Here we have to have control over them, as we have heard.

My question is, if there is a central federal hospital, could the various provinces pass legislation whereby a man found to be an addict could legally be committed to the central federal institution.

Mr. VARCOE: I do not believe that one province could commit an addict for detention in another province. I have not thought about that, but I feel sure it would not be constitutional.

Senator HODGES: To have a federal institution?

Mr. VARCOE: No, not if you are relying on provincial laws for their detention.

Senator STAMBAUGH: It would have to be a federal law?

Mr. VARCOE: Yes.

Senator BEAUBIEN: It would have to be the same law in each province?

Mr. VARCOE: The Opium and Narcotic Drugs Act is really administered by the Health Department, including the enforcement.

The CHAIRMAN: Then you think you cannot pick up a drug addict solely on suspicion?

Mr. VARCOE: Suspicion of what?

The CHAIRMAN: Of being a drug addict.

Mr. VARCOE: It is not a crime to be a drug addict.

Senator HODGES: Could you pick them up in any way, apart from the criminal side, as people who are suffering from a contagious disease? If you have people suffering from small pox, you can pick them up, and put them in isolation.

Mr. VARCOE: You would have to persuade parliament that it was a national question, something like an epidemic of cholera, something which was a threat to national life. Then you might be able to pass a law which would make it possible to commit people merely on the grounds of addiction.

Senator HODGES: But not criminal tendencies.

Mr. VARCOE: That is right.

The CHAIRMAN: The question is very difficult, we realize.

Mr. VARCOE: Yes.

The CHAIRMAN: There will have to be some stringent laws provided.

Mr. VARCOE: Yes.

Senator STAMBAUGH: Some provinces are rather touchy on what they consider infringements of their provincial autonomy.

Senator KING: An addict is known to the police; could we send him back home if he came from some other place? I am not speaking of the criminal addicts, but the ones who are known as addicts, but are not residents of Vancouver, for instance, where the police seem to know all about them. They do pick up other people and send them back home.

Could that be done?

Senator HODGES: In that case you would not solve the problem. You would simply be dispersing it.

Senator KING: The problem is all Vancouver, as I see it.

The CHAIRMAN: And seems to be increasing too. After all, a drug addict is not contributing to society. He is not working, but is simply loafing around and burglarizing to live. If he came from another province, why could he not be sent back, either as a vagrant, or a menace to society, if he is known as a drug addict?

Senator HORNER: The chief of detectives in Montreal told us that one addict was responsible for one hundred thousand dollars worth of thefts, and they could follow the pattern of breaking into houses, and that sort of thing, which this man was carrying on.

So it seems to me if there could be devised any method for putting those people away, it would relieve a great deal of this petty thieving, which is costing the country so much.

The CHAIRMAN: One thing which made us realize the situation in British Columbia was that in Montreal and Toronto the police are picking up these people as vagrants, and that keeps them stirred up. I am not sure they are doing that in Vancouver even if they are drug addicts.

A drug addict is not working; he is loafing around in the daytime, and at night is probably pocket-picking, or committing some other form of thievery.

Senator HORNER: What about the law which permits the arrest of a man if he has no visible means of support?

Mr. VARCOE: That is vagrancy. There are provisions in the criminal code for arresting and imprisoning vagrants. I do not know to what extent they use that law, in that connection.

Senator HODGES: They have not the places to put them. Our jails are crowded now and our penitentiaries are crowded. That may have something to do with it. If you are going to pick up all the vagrants, you would certainly have to provide places to put them.

The CHAIRMAN: I am thinking of the vagrant addict.

Senator KING: You do not care to answer my question, Mr. Varcoe?

Mr. VARCOE: Will you please re-state it? I did not understand what the legal point was.

Senator KING: When a vagrant, especially if he has been in jail, is loitering around the streets and is not employed, the police are able to get him out of town, and even his fare is paid on many occasions. Such persons are well known to others, perhaps, and they may have served time in Vancouver, but are not residents of Vancouver.

Mr. VARCOE: That might be done. I think you could enact a law providing that upon a person being convicted of an offence in, say, Vancouver, at the conclusion of his term of imprisonment, or whatever punishment was meted out, he could be returned to his home province.

Senator KING: If he is unemployed?

Mr. VARCOE: Yes.

Senator KING: It occurred to me that Winnipeg is not worried, Toronto is not worried, Montreal is not worried, but we in British Columbia are greatly worried.

Senator BAIRD: You think there are many addicts probably from Toronto or Montreal—

Senator KING: I think they are chasing them harder in Toronto, Montreal, Winnipeg, and Edmonton. There is no addiction in Victoria.

Senator HODGES: We are law-abiding people in Victoria.

Senator BAIRD: Would you agree with the suggestion that we put them out on some island?

Senator HODGES: Yes, stick them on a little island in the Pacific, if you like.

Senator STAMBAUGH: You would not solve any thing by picking them up as vagrants, sentencing them, and then sending them out of town. That would not solve the problem, and never will.

Senator KING: It might not be much of a solution.

The CHAIRMAN: I cannot get it through my mind that it is the climate of Vancouver that is drawing the addicts to Vancouver.

Senator HORNER: You have more alcoholism in Vancouver than any other par of Canada.

The CHAIRMAN: Have we?

Senator HORNER: Yes. I think we have evidence of that.

Mr. VARCOE: Can you accept the evidence of a person's physical condition as raising the presumption that he has been guilty of an offence?

Mr. LIEFF: Mr. Chairman, I have just been chatting with Mr. Varcoe, and there is an analogy with the Official Secrets Act, as raising a presumption of contact with the enemy. They pin-pointed in the Official Secrets Act that things which you presume contact with a foreign power.

Senator BAIRD: There are other diseases besides drug addiction, which have their own peculiarities.

Senator STAMBAUGH: A person would show inside of twelve hours to any physician whether he was an addict or not.

Senator HORNER: You would have the proof in his reaction and his illness after you arrested him. It would be discovered very shortly that he was an addict.

The CHAIRMAN: The statement was made to us by one of the police, pointing out the difficulty of getting evidence. He said it is well known that a "pusher"—that is, a seller of drugs—may have in his mouth a little bag of capsules, and when approached by the police, will swallow it.

Is there anything in the law to prevent the police from picking them up? The police in Vancouver said they had some difficulty, even though they knew the "pusher" had swallowed it, and they were afraid of breaking some law by picking him up on the suspicion. Could a man be picked up on the suspicion of that kind?

Mr. VARCOE: A man can be picked up—

The CHAIRMAN: And held for twenty-four hours, to find out if he swallowed it?

Mr. VARCOE: The law could be amended to produce that result.

Senator BEAUBIEN: You mean the Opium and Narcotic Drug Act?

Mr. VARCOE: Yes.

The CHAIRMAN: The problem is so acute out there that some steps must be taken. There is no doubt about that.

Senator HORNER: Not only there, but all over Canada. I hope it is as good as they claim it is in Montreal, but it is scattered throughout the little towns in Quebec, particularly along the American border, and when you travel about the country listening to different individuals you will realize that it is scattered throughout the country.

The CHAIRMAN: If Montreal has less than 200 addicts, with a population of nearly 2,000,000, there is certainly no drug problem there.

Senator BEAUBIEN: In Vancouver, the big difficulty facing the enforcement officers, those enforcing the Drug Act, is that although they know a man has a drug on him, when they go to get him he would probably swallow the one or two pills he has in his mouth, and they have no evidence. In fact, there was one case where one man went to a hospital, and it took two or three days, giving him sedations—

SENATOR HORNER: In that case they held him for eight days. The police admitted they were holding that man without any amendment to the law. They saw him swallow the narcotic.

Senator KING: They had no authority to hold the man at all.

Senator HORNER: They had no real authority to hold him, but they held him.

The CHAIRMAN: Could a change be made in the law to allow the police to pick a man up and hold him for a certain length of time?

Mr. VARCOE: There could, but the House of Commons might object to that.

The CHAIRMAN: Are there not many kinds of other people picked up and held on suspicion? That can be done. Why could it not be done with drug addicts?

Senator HORNER: You say that Montreal has a population of 2,000,000 with from 200 to 250 addicts. To me, that is serious enough, because when you think of England with 50,000,000 people, and only 300 addicts—

Senator BEAUBIEN: 300 known addicts.

Senator HORNER: That is what they said in Montreal, that they had 200 known addicts.

The CHAIRMAN: Britain has no criminal addicts, so it is a different situation entirely. As a matter of fact, Mr. Walker said they would not know how to handle the problem, if it was the same as we have here.

Senator HORNER: Dr. Richmond said he never ran into a case in England.

The CHAIRMAN: We heard one man say last week that he handled only about twenty drug addicts in Britain in twenty years. His story was in conflict with some of the other things we heard. I never quote Britain against this country, because the conditions are so different.

Senator HORNER: I think it is serious all over. I know it is in Vancouver.

The CHAIRMAN: Have Honourable Senators any further questions to ask of Mr. Varcoe?

Senator HORNER: You think we might have some difficulty in amending the Criminal Code to make it an offence to take drugs, to give the police authority to arrest them?

Mr. VARCOE: I do not know how that could handle it. Certainly an amendment could be made. There is no doubt about that. Whether it would be acceptable to Parliament or not, I do not know.

It would depend, I suppose, to some extent, on how vigorous a report was made by this committee to support such an amendment.

Senator HORNER: Personally I would be inclined to favour recommending it.

Senator BAIRD: Do you not think it is more on the provincial level?

Mr. VARCOE: I have thought so throughout. I think, as far as addiction is concerned, it is a provincial problem, just the same as alcoholism.

The CHAIRMAN: But when the provincial problem gets out of hand, as it has in Vancouver, under the Federal Act, it becomes our problem.

Senator HORNER: The Federal Government has to do with the Criminal Code?

Mr. VARCOE: Yes, that is the drafting of the Criminal Code.

Senator HORNER: Do the provinces administer the Criminal Laws as enacted by the Federal Parliament?

Mr. VARCOE: That is right.

Senator KING: If you had such an amendment applicable to drug addicts, you would have to also provide for the alcoholics.

Senator STAMBAUGH: We would not have to.

The CHAIRMAN: Alcoholism is getting very serious, Senator King.

Senator HODGES: If you want to make it purely a provincial matter, it is a question of segregating the addicts by putting them in an institution. Would that mean that the province would have to pay the cost of the erection of an institution, and the staffing and maintenance of it?

Mr. VARCOE: I suppose Parliament could appropriate funds for that purpose, but it is largely a provincial matter.

Senator HODGES: It hardly seems fair that a province should have to bear the cost of an institution like that.

Mr. VARCOE: There would be no difficulty from a legal point of view, if Parliament appropriated money for that purpose.

The CHAIRMAN: If the sentences are for two years less a day, it is a provincial problem. If they are over two years, then it is a federal problem. Let us get the proper picture. This crime is being committed under the Federal Government, and if a man is put in the "pen", it is a Federal responsibility.

Senator HODGES: I am speaking solely of addicts, not the "pushers" or traffickers.

My point is if the province of British Columbia is expected to erect, staff and maintain an institution for the control of, say, 2,000 or 3,000 drug addicts, we will have more than the province can stand, as far as British Columbia is concerned. The staffing alone would be an expensive affair.

Senator HORNER: Do you not send them back in other cases to the province from which they came? For instance, in regard to the old-age pensioner, you have to be a resident for so long in a province. Could there not be some loop-hole, whereby a person arrested in Vancouver could be sent back where he came from?

Senator HODGES: That is more a federal matter.

Senator BEAUBIEN: That is only between the ages of 65 and 69. If you are 70, and a resident of Canada—anywhere in Canada—you are entitled to the Old Age Pension.

The CHAIRMAN: Honourable Senators, are there any further questions to ask of Mr. Varcoe?

If not, on behalf of the committee, Mr. Varcoe, I wish to thank you very much for coming here, and for the information you have given us.

The further proceedings of this committee adjourned tentatively until Tuesday, the 7th of June, 1955, at 10:30 o'clock in the forenoon.

THE SENATE

SPECIAL COMMITTEE ON NARCOTIC DRUG TRAFFIC

Ottawa, Tuesday, June 7, 1955.

EVIDENCE

The special Committee on the Narcotic Drug Traffic met this day at 10.30 a.m.

Senator Reid in the Chair.

The CHAIRMAN: Honourable senators, it is half past ten, and we have a quorum, and if you will kindly come to order, we will start our proceedings this morning.

We have three witnesses, Mr. R. E. Curran, Legal Adviser, Department of National Health and Welfare, Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries, and Inspector J. J. Atherton, of the Royal Canadian Mounted Police.

Before calling upon the first witness, I would like to make a brief statement.

Last week I had to visit Washington in regard to a meeting of the International Salmon Fisheries Commission. Mr. Anslinger, the Chairman of the Senate Committee on Narcotics knew I would be in town and got in touch with me at the hotel. I had quite a long interview with the Chairman of the United States Senate Committee, who urgently requested I appear before his committee. I told him I could not because I had to be back in Ottawa on Thursday, but I had with me Mr. Curran, the Legal Adviser of the Department of National Health and Welfare, whom I am sure would make a statement to the committee, and tell them how far we had gone with our committee here.

There was one thing which pleased me very much, which I thought I should pass on to the members of the committee here.

The Chairman of the United States Senate Committee studying narcotics, when he heard how far we had gone in a short time said "We may have to come up to Canada to learn a few things; I think you are further ahead in your investigation in Canada than we are in the United States."

I thought I would pass that information on.

I want to distribute these booklets which came from the Treasury Department. Mr. Curran took copies of our investigation with him, and in return they gave us copies of theirs.

May I just say to the honourable senators that we are working now on our report, and I expect early next week we will have the report ready, and it will be placed before this committee, which is to make the decision regarding the matter, and I will ask honourable senators if they will kindly do this: The press is extremely anxious to know what we will recommend. I told them that so far I have no view of what the recommendations will be, that they will be the recommendations of this committee, and I will ask every honourable senator, when he gets a copy of our report, to hold the matter in secret, and that nothing be given out until we present our report in the Senate. I think it would be just terrible if something got out before we presented our report to the Senate, and I will ask every honourable senator to keep the matter entirely secret until the report is presented.

Mr. Hossick has a statement to make before I call upon Mr. Curran. Mr. Hossick is the head of the Department of Narcotics, under the Department of National Health and Welfare, and he has a statement, and I think now will be the best time for him to make it.

I will, therefore, call upon Mr. Hossick to make his statement at this time.

K. C. HOSSICK, *Chief, Narcotic Control, Department of National Health and Welfare.*

The CHAIRMAN: Will you please proceed, Mr. Hossick.

Mr. HOSSICK: Mr. Chairman and honourable senators; I would like to file for your information, some statistics which I have been asked to prepare in connection with the convictions under the provisions of the Opium and Narcotic Drugs Act during the past ten years. This statement has just been prepared and shows the type of charge laid and the sentence which has been awarded in each case. It has been prepared on a provincial basis.

(See Appendix T)

I took a ten-year period because it shows the upward swing from one province to another. In other words, if we take the total number of convictions in the province of Ontario during the year 1945, which amounted to 65, we find that in that year there were 46 in the province of British Columbia,—that is, the total in that province—and you will also find the range of sentence awarded.

Then if you consider the year 1954, you will find that Ontario has a total of 80, as compared to a total of 192 in the province of British Columbia.

I thought this statement might be of value to the members of this committee, when they are considering their final report, and engaged in its preparation.

Also, Mr. Chairman, with your permission, I would like in the next few days to table a report with regard to the scientific research on narcotics, which has been a project of the food and drug laboratories of the Department of National Health and Welfare, (See Appendix U) and in this case I would like to speak to you, not as the Chief of the Division of Narcotic Control, but as the Canadian representative on the International Narcotic Commission of the United Nations.

This year the Canadian delegation devoted much time to the scientific research into opium origin identification. We were successful in getting a resolution through with regard to this matter, and it is hoped that when this program of research identification has been developed, we may arrive at some conclusions in regard to the actual source of opium in the illicit traffic. That is the main object of this type of research.

I would like to pay tribute to the scientists who have developed this program, to Dr. Charles Farmilo, of our department, and his associates. They have done some wonderful work in this regard, and, as honourable senators will notice, when you consider the evidence of Dr. Isbell, of the Lexington Hospital in Kentucky, that he indicated in his opinion the Canadian research in this field was the finest in the world. We have two methods of determining identification, one is the Ash method of identification, and the other is the Electrophoretic method of identification, and we feel very proud that Canada has played such a leading part in this type of research.

I believe, with your permission, it will be desirable to file a statement of this kind.

Senator KING: Would you explain what you mean by "method of identification"?

Mr. HOSSICK: That is the identification of the origin of opium. If opium in the illicit traffic has been seized, and put through a chemical process, it is practically possible to tell you exactly where that opium has been grown.

Senator HORNER: Would it give the identification of the channels through which it arrived here.

Mr. HOSSICK: That would be very difficult, Senator, but if we go so far as to identify the country of origin, it does not mean that particular country is the guilty party, but we can ask that country, through the international organization, to take steps to prevent the further seepage of opiates into the illicit traffic which may in time reach North America.

Senator McINTYRE: The fact that the figure in British Columbia is much higher than for Ontario, while Ontario has five times the population of British Columbia,—would that indicate the fact that it is more convenient for the traffic to land there, with their drugs.

Mr. HOSSICK: I do not think I can answer that question, Senator. You have heard enforcement officers give their views. Some of them think it is the climatic condition of British Columbia which attracts the addicts. I can say quite frankly that the source of the illicit movement of drugs is certainly not through the Western Canadian coast, as far as we know. All our information points to traffic from the east, toward the west.

Senator McINTYRE: That is, it comes in to Canada in the east, and goes from there to British Columbia.

Mr. HOSSICK: That is the concentration at the moment, from the information at our command.

Senator HORNER: Senator McIntyre, we found another strange thing while we were in British Columbia. While liquor is equally available throughout Canada, there were more alcoholics in British Columbia than in the east.

Senator McINTYRE: They may distil it better out there, for all we know.

Senator HORNER: Well, I do not know about that.

The CHAIRMAN: Honourable senators, we have three witnesses this morning, the first is Mr. R. E. Curran, Legal Adviser, Department of National Health and Welfare, who has been across the line and will present the United States picture to us. I would ask him if he will now come forward.

Mr. R. E. CURRAN, *Legal Adviser, Department of National Health and Welfare.*

The CHAIRMAN: Will you proceed, Mr. Curran?

Mr. CURRAN: Mr. Chairman and Honourable Senators:

In the interests of brevity, I will first table with your permission, copies of the federal narcotic legislation which is in force in the United States, which was given to me by Commissioner Anslinger of the Bureau of Narcotics for this purpose.

I table, therefore, seven statutes and regulations thereunder which cover at the federal level in the United States all of their narcotic legislation. These, perhaps, can be listed in the record. Later on I will file the text of the statement given by Commissioner Anslinger last Thursday to the Senate Judiciary Sub-Committee on narcotics. This statement deals with the general narcotic picture, but amongst other things, explains something of their federal narcotic legislation and also something of state legislation as it also pertains to this subject.

The CHAIRMAN: May I say to Senators King and Beaubien, who were not here at the opening, that I have passed the message I received from the Chairman of the United States Senate Commission, that when he heard how we had

gone along here, he thought they had better come to Canada, because we were further ahead than they are. I thought that was a very nice compliment, and I should repeat it to the committee.

Will you proceed, Mr. Curran.

MR. CURRAN: Meanwhile, Mr. Chairman, I should like to explain for the convenience of the Honourable Senators, that in the United States the federal legislation is in the nature of taxing measures designed to have the effect of regulating the domestic trade and distribution of narcotic drugs.

This legislation is not in the nature of criminal law because in the United States, criminal law is wholly a State responsibility and not a federal responsibility. The reverse is the situation in Canada where criminal law is a federal responsibility and our Narcotic Act is criminal law. In Canada we therefore have one narcotic law which is applicable to the whole of Canada as it is criminal law. In the United States, however, the situation is considerably complicated because of the constitutional division of responsibility between the federal government and the states.

The federal legislation as I have said rests on taxation and is concerned with the question of whether or not drugs are legally entered and have paid a legal tax. Their direct interest, therefore, is on the basis of taxation rather than as criminal law enforcement which is, of course, the indirect but real purpose of the enforcement. This division raises amongst other things, serious difficulties, one of which is the lack of the right on the part of narcotic authorities to search an individual or his effects. That has to be done under the criminal law authority which, as I have said, is wholly a state responsibility.

It will sometimes happen that the federal narcotic authorities will invoke the assistance of a local police authority to conduct a search which he could do.

The seven statutes which I have tabled comprise the federal legislation, but in addition to these, each state has some form of narcotic legislation. As is pointed out in Commissioner Anslinger's statement, at present all except five States have a uniform narcotic law and all except three States have adequate narcotic legislation for effective enforcement.

The governing federal statute insofar as penalties are concerned, is contained in what is called the Boggs Act. This amended the penalties provisions of the original Harrison narcotic law and other of their narcotic statutes.

It provides for minimum penalties of from two, five or ten years for first, second and third time offenders respectively.

Senator HORNER: You mean selling narcotics?

Mr. CURRAN: Yes, a minimum of two years.

Senator HORNER: For selling?

Mr. CURRAN: For any offence, including selling.

Senator HORNER: Not for addiction.

Mr. CURRAN: No, it is an offence, however, to be in possession. The federal authority does not deal with addiction as such. It cannot. It can only deal with the question of whether the tax on a drug has been paid—that is, the legal tax. There are some 200,000 registrants in the United States who are authorized to deal in drugs, including the medical profession, wholesale and resale dealers, pharmacists, and so forth. So their whole approach is by taxation, not through the criminal law.

Under federal narcotic law the Judge has the power to suspend sentence for a first offence, but not for a second or subsequent offence. From an enforcement point of view, the suspension of sentence is often considered to be in the nature of a weakness.

Senator HORNER: Of a weakness?

Mr. CURRAN: I gathered that they consider the right to suspend sentence to be a weakness.

For a second offence the law imposes a minimum of five years with no right of suspending sentence nor right of probation.

When I visited the Lexington hospital last week, attention was drawn to the inflexibility of this provision from the point of view of treatment. The authorities at Lexington will receive a man for treatment who has been convicted of a second offence and has accordingly been given the minimum of five years, and for whom probation cannot be given. In other words, they can treat the patient at the hospital but he cannot be released on parole until he has served his five years, less whatever time off he has earned for good behaviour. They feel that in some ways this is an unfair imposition because the treatment of an individual may be such that they consider him suitable for release at the end of a year or perhaps two years, but he is not eligible for parole until the full sentence has been served.

Senator KING: There is no suspension on a second offence?

Mr. CURRAN: No.

I should mention at this point that Commissioner Anslinger informed me that nineteen of the States of the United States have also enacted legislation which is identical with the Boggs Act. The Boggs Act as I mentioned, deals with the question of penalties for narcotic violations and there is accordingly uniformity as to penalties between the federal legislation and the states enacting such legislations.

Commissioner Anslinger's statement deals extensively with legislation and penalties but it may be interesting to point out one or two observations that he made in testifying before his Committee last week.

He emphasized something of the problem which is faced in the United States because of differences in state laws. He gave as an illustration of this, the present situation in the State of Ohio. Ohio's narcotic laws do not presently provide for as severe penalties as do the laws in the states surrounding Ohio. There accordingly has developed in the State of Ohio a serious narcotic problem due to the movement into that state of the problem from the higher penalty states which surround it. He explained that to meet this situation, legislation has recently been introduced before the Ohio legislature to raise the narcotic penalties in the state to be equal to, if not more severe, than those of the surrounding states. This is in an effort to combat an increasing problem which Commissioner Anslinger explained, developed in this way.

As an illustration of high penalty laws, the State of Michigan, I understand, provides for a maximum of twenty years. Some of the States deal with the problem of addiction as an offence separate from that of the illicit possession of drugs.

For example, New Jersey designates a drug addict as a disorderly person punishable by a fine of \$1,000 or one year imprisonment, or both.

The State of California makes addiction an offence, and a man can be put into the Work House, which is a form of correctional institution.

Michigan has what is called the "Needle Law"; in other words, the possession of a hypodermic needle without a doctor's prescription is an offence.

Other states have different types of approaches, but I think I have indicated sufficiently the types of things which may be interesting to this committee.

The Federal Bureau of Narcotics, according to Mr. Anslinger, maintains a force of agents for the enforcement of the narcotic laws.

Senator HORNER: This is, apart from the local police?

Mr. CURRAN: Yes. They have their own narcotic enforcement agents.

Commissioner Anslinger pointed out that at the present time they have some 250 narcotic agents which is a force about the size of the average police force of a city of from 200,000 to 300,000 population.

He was quite surprised to find the large number of special Royal Canadian Mounted Police narcotic officers we have in Canada, and he told me he felt that on a comparable population level, they should have a great many more in the United States than we have here.

The States also maintain narcotic enforcement agencies, and there is also the city police, with whom they work in co-operation. The situation is comparable to that in Canada, where we have the Royal Canadian Mounted Police working in co-operation with the provincial and municipal authorities.

In the United States it is very much the same as here. Commissioner Anslinger stated that the degree of co-operation between his force and state and municipal forces was on the whole, quite satisfactory. He made reference to areas where this might vary, and also to areas where the situation was complicated by other factors as, for example, legalized gambling in the State of Nevada. I gathered, however, that he is well satisfied with the kind of co-operation that his force on the whole, receives.

In addition to that, the federal narcotic division maintains agents abroad, so that the authorities in the United States will have definite information, if possible, as to the movement of drugs and from where they are coming.

Senator KING: Is there any organization to which these agents report, or do they simply report to their own organization?

Mr. CURRAN: These agents report only to their own authority in the United States, that is, the Federal Narcotic Agency, which in turn makes a report to the United Nations.

Senator HORNER: They co-operate closely with Washington, and also with the officers in the district where they are working.

Mr. CURRAN: Yes. These, generally speaking, are responsible to the Agency in Washington, and, in turn, to the United Nations.

Senator LEGER: Does Canada get any of that information?

Mr. CURRAN: Mr. Hossick secures a great deal of information from Mr. Anslinger from time to time.

Mr. HOSSICK: That is quite true. We also secure a considerable amount of information through the traffic section of the United Nations, of which I happen to be a member.

Mr. CURRAN: I think that outlines the legislative picture, and I will be glad to answer any questions, if I can.

Senator GERSHAW: May I ask, Mr. Chairman, if the fact that the penalty is less severe in one state, makes the addicts seem to gather in greater numbers in that particular state?

Mr. CURRAN: That was Mr. Anslinger's considered opinion, that in areas where the penalty is lighter or the enforcement was more lenient, there was inevitably a flow of traffic to that state.

Senator HORNER: He said that Ohio was proposing legislation at the present time.

Senator GERSHAW: Yes, that is another point. Another question I would like to ask is, where addiction is a crime, did you receive any information as to how they diagnose addicts?

Mr. CURRAN: Yes. As I mentioned a moment ago, addiction is a misdemeanour in the state of California and punishable by sentence in a correctional institution. Some two or three years ago while in California, I spent some time with the Chief of the Division of Narcotic Enforcement, which is

a state enforcement agency, and I enquired as to the means of proving a case of addiction. The Chief said, in the first place, a person would not likely be picked up unless there was good reason to suspect him of addiction and in the majority of instances the man would admit to being an addict when asked. In cases where he did not admit to addiction, the authorities would accept evidence of fresh needle marks, together with medical evidence as to his withdrawal symptoms which would become very apparent in a matter of six to eight hours. These were considered sufficient proof to support a charge of addiction where the man did not make an admission to that effect.

Senator HORNER: Were they satisfied they are helping them?

Mr. CURRAN: No. There was no evidence from the California people that they regarded it as any real solution for the problem. It may put a man out of circulation for up to ninety days, but without the proper facilities for treatment, and a follow-up program after release, they do not feel that it is bringing about a solution to their problem.

The CHAIRMAN: Commissioner Anslinger was very emphatic about that, and he showed us a list of certain cities and states, showing there were drug addicts where the law was lax, but where the law was severe, there were none. What surprised me was the statement that in the city of Seattle, a city comparable to Vancouver, in the same section of the country, 120 miles south of Vancouver, there is less addiction than there is in Vancouver. So the statements which have been going out regarding the climatic conditions being a factor, do not seem to be borne out.

Senator LEGER: Is the law strict there?

The CHAIRMAN: Yes, the law is severe there.

Senator HORNER: Did you learn anything about the salaries the narcotic agents receive in the United States?

Mr. CURRAN: No, I cannot answer that. I spoke to a number of agents. I think it is fair to make this statement, that the salary is not always the determining factor in attracting a man into this type of enforcement. They become dedicated people, and they are not always worrying about the salaries, but have become dedicated to the challenge the problem presents.

The CHAIRMAN: And they would make the best type of officials?

Mr. CURRAN: Yes. Following along what the Chairman said a moment ago, Commissioner Anslinger mentioned that in connection with the city of Seattle there had been a conference between the Judges, and I believe the Attorney General, and the enforcement authorities respecting the drug problem. As a result of this, it was stated by way of warning to all people who might be involved with drugs that if they came before the courts and were convicted they could expect to be dealt with very severely. Commissioner Anslinger said that this apparently had had a very salutary effect on the drug community which is now relatively clean. He mentioned that this type of thing had been done in other areas where federal and state courts commenced to impose heavier penalties following some open declaration to the drug world. He comments on this at page 10 of his statement where he says that where this has been done consistently, the drug traffic has notably decreased as in New Jersey, Florida, Maryland, Virginia, the Northwest and other states. He pointed out that on the basis of experience, drug addicts when they realize that things are getting "tough" will move to another locality where life is easier for them.

I have mentioned the statement of Commissioner Anslinger which I would now formally file and, if I may do so, commend it to your perusal as it is a very interesting review of the drug problem from his point of view. I will also file a further statement of Commissioner Anslinger which deals with the

incidence of the drug problem in the United States. In connection with this latter document there are eight exhibits which give a great deal of statistical information covering the geographical distribution of drug addicts in the United States, arrests and convictions by states and cities, division between male and female addicts, amongst other details. (*See Appendix V.*)

Mr. CURRAN: The exhibits and the summary which I have just filed covers a survey which is presently in progress in the United States to find out factually the size of the drug population.

This survey has been in operation for some 28 months and its purpose is to obtain the names, as well as some data with respect to every known addict in the United States.

Various estimates and guesses have from time to time been made respecting the size of the drug population. These estimates have ranged from 10,000 to 100,000 addicts in New York City alone, and to many thousands in other large areas. Because of the very wide range of estimates of the drug population, the Bureau of Narcotics decided to obtain factual information and which would give as accurate a statistical picture of the problem, as was possible.

Forms in quadruplicate were drawn up and sent to all enforcement agencies in the United States, i.e., federal, state, city, municipal, county and so on. Everyone who was concerned with criminal enforcement anywhere, was furnished with these forms and asked to fill in and return them to the Bureau of Narcotics. The forms give the names of the addicts and as much information respecting them as is known.

On the basis of the forms so far returned to the Bureau, they have record of some 29,000 known drug addicts in the United States.

Commissioner Anslinger reported that these forms are being received at the rate of approximately 1,000 per month and he expects that when all forms are in, the total number of addicts in the United States will be found to be in the neighbourhood of 60,000.

Commissioner Anslinger drew the Committee's attention to an important point that has developed in recent years and is well brought out in the survey. Some ten or fifteen years ago the greater number of drug addicts were from the white population of the United States. At the present time, there is a complete reversal of that situation, and the majority of the drug addicts at the present time are coloured.

Commissioner Anslinger is anxious not to include in his addict figures those who use marijuana only. He desires to confine the survey to heroin, morphine and other kinds of drug users. He pointed out to the Committee that insofar as Canada's drug problem was concerned, and that in the United States, a comparison could be made on a per capita basis subject to two factors. The first being that Canada has no coloured addict problem, and the second that Canada has no marijuana problem. If, therefore, the United States situation could be related in terms only of the heroin problem with the white population, he felt that it would on a per capita basis, approximate that in Canada.

Senator GERSHAW: Assuming our population is 3,300—that is our addict population.

Mr. CURRAN: We were speaking about the criminal addict population, and I think the figure mentioned here was 2,400. They have the other types of problems too, but he was speaking of the criminal addicts.

Senator BEAUBIEN: Why has the change been made from the white to the coloured? Is it because of the economic situation?

Mr. CURRAN: I can give you only a very general answer to that. The authorities with whom I spoke on this part of the problem, thought it was partly due to economics and to the high employment situation which has followed the war.

At Lexington, they pointed out that while they have no exhaustive follow-up facilities, the number of white addicts whom they have had at their institution, and who have not returned or otherwise been reported as being addicted, would seem to indicate that a number of them have maintained employment and have abstained from the use of drugs.

While there is a good deal of addiction in the South amongst coloured persons, the higher incidence of addiction is in New York and Chicago where the addicts are, as I have mentioned, principally of the coloured population. That, I think, is about all that I can usefully say with respect to the question.

Commissioner Anslinger in giving his evidence to the Committee raised a point which he had previously discussed with your Chairman and myself. This involved the question of a legal difference between the "addict trafficker" and the "non-addict trafficker". He emphasized in his evidence to his Committee that there should, in his view, be no such difference. He urged that no sentimental distinction should be made between kinds of traffickers. He stated that as the evil with which he was endeavouring to cope was the drug traffic, the only way in which it could successfully be accomplished, was that trafficking in any form, must be seriously regarded.

He pointed out that if you are sympathetic to the addict trafficker or permit him to be in a position to attract sympathy because of his weakness, you are thereby weakening the very purpose of enforcement, and at the same time, attacking a relatively small part of the whole problem.

The CHAIRMAN: In other words, a man who steals one dollar is as much a thief as a man who steals \$100?

Mr. CURRAN: Yes, that is it. As an illustration—the reason that a bank robber has for robbing a bank, such as his desire for luxury, is not considered a legal justification for sympathy to him. At the same time, the man who peddles drugs because he also wants drugs, is not justification in breaking the law. I thought I would mention this particular point because it is one that has been raised from time to time and the Honourable Senators may recall that in the Vancouver Community Chest submission, some emphasis was placed on the desirability of distinguishing between the big trafficker and the little trafficker, and this distinction in turn, to be generally related to the question of addiction or non-addiction by the trafficker.

Mr. Anslinger read in our evidence the statement that there was little or no heroin problem in Japan. He said that is not true. He said that the heroin problem in Japan today is worse than it is in the United States and Canada combined, and he asked me to make that statement to this Committee, so our records could reflect the situation as it is.

Senator LEGER: How about our soldier population in Japan?

Mr. CURRAN: I asked at Lexington if they had any members of the armed forces, and they said they have not had a single soldier enter for treatment, and he did not know whether they did not have any addicts in the army, or whether the army itself looked after them.

Senator KING: I think the evidence was there were not any.

Mr. CURRAN: He indicated that he did not think the problem was one of any great magnitude.

The next matter that was raised before the Committee in Washington, and respecting which I was particularly asked to comment, involved the question of free drugs to addicts or what Dr. Isbell referred to as "Narcotic Bars".

Commissioner Anslinger paid very high compliments to the Canadian authorities in their approach to the drug problem, and mentioned my small participation, on the basis of which Senator Prince Daniel, the Chairman of the Senate Committee of the United States Senate, asked me to appear as a witness. I was accordingly called and I gave to the Committee a statement from the Chairman of this Committee and I also answered a number of questions put by the members of the United States Committee as to the Canadian situation as it has been developed in the evidence that you have heard up to the present time.

It was pointed out to me that the provision of free drugs to addicts as a means of solving the problem was frequently advanced, and while many authorities are opposed to it, it nevertheless, has some support as a solution. I told the Committee that practically all of the addicts who had appeared had themselves advocated free drugs as a solution to their problem.

I, however, pointed out that on the other hand, responsible evidence of the highest and more authoritative kind unqualifiedly condemned the provision of free drugs to addicts under any circumstances. I stated that without attempting to predict what view the Committee would take, I was certain that at least it would be in favour of drug free areas, rather than free drug areas. I hope, Sir, that I did not take too much upon myself in offering that interpretation of the situation, but in view of all of the evidence that has been heard, I thought at the time it was a proper statement to make.

The Chairman of the Committee, as well as Commissioner Anslinger were interested in our system of reporting through Mr. Hossick's department, and through the Royal Canadian Mounted Police.

I explained the reporting system which was established in the Division of Narcotic Control of the Department of National Health and Welfare covering the entire importation, distribution and legal use of narcotic drugs in Canada for medical and scientific needs. I also explained how, in addition to this, a card system was maintained covering every known addict in Canada, either criminal or medical, and supplementary to this, the reporting system of the R.C.M. Police through their Finger Print Bureau and the exchange of information between the R.C.M. Police, other Police Forces and the Division of Narcotic Control.

The Chairman commented favourably on the thoroughness of our system.

The CHAIRMAN: He said he was coming up to see it.

Mr. CURRAN: Yes.

The last thing which I think I should perhaps mention is that I went to Lexington, Kentucky, and spent two days with Dr. Isbell there, who very kindly showed me all of their facilities, and he gave me some very interesting facts and figures, which I might mention briefly. He said they had a total inmate population of 1,300. They receive people who have been convicted of federal offences, and who are drug addicts, and also people who are drug addicts who apply on a voluntary basis. He told me that 70 per cent of the total inmate population were prisoners, that is, they are people who are serving sentences imposed by the federal courts, and have been transferred by the Bureau of Prisons to the Lexington Institution for treatment, and that they are required to serve out the entire sentence in Lexington.

There is some arrangement whereby they can be sent back to the penitentiaries under certain conditions, but it is rather a difficult thing to do, and the majority of them stay in Lexington until their whole sentence has been served.

On the other hand, they have an annual turnover or admissions of patients of some 3,500 of whom 75% are admitted on a voluntary basis. At first it seemed a contradiction to say that 70% of the inmates were prisoners with 75% of the admissions being voluntary. The answer, of course, lies in the fact that there is a high turnover in the percentage that come in on a voluntary basis, i.e. a volunteer for treatment can leave when he likes, and a number do leave under

30 days, a majority perhaps within 60 days, and with a few remaining for the recommended 4½ months period. This, I think, accounts for the high percentage of admissions in proportion to the number of prison inmates.

The Honourable Senators may recall Dr. Isbell speaking about the need for legal control over voluntary admissions and particularly when they are admitted for a second time. He made reference to what he called the Kentucky Blue Grass Law under which an individual can be committed for a period up to one year. This, I understand, was the legal device whereby the institution formally gained legal custody of volunteer addicts who were returned for treatment for a second time.

Dr. Isbell explained, however, that they have recently received a directive whereby they no longer use the Blue Grass Law. Volunteers, therefore, can come and go on a voluntary basis. If a volunteer, however, leaves against medical advice, it is not so easy for him to gain re-admission. The authorities have some discretion about accepting him a second time, and this is generally exercised in accordance with the available bed space, amongst other things.

Senator HORNER: Would those sent from other states to Lexington be the less-hardened criminals?

Mr. CURRAN: They are people who have committed federal offences, and are sentenced by the federal courts, and then the Bureau of Prisons will decide whether they will go to Lexington or not.

I asked the same question you asked, Senator, if in Lexington they had very case-hardened prisoners, and he said the Bureau of Prisons would be very reluctant to send a hardened criminal to Lexington. It is for them to decide, and they try to use some selectivity in getting those into Lexington who they think might profit from it.

They have a number of doctors who are patients. Some of them are prisoners, and some are there voluntarily, and are people who have not committed any crime or offence.

I spoke to one inmate the other day, who was a trafficker, and was doing eight years. He had done two and had five yet to go.

Senator HORNER: Do you think the treatment they give them is a good idea?

Mr. CURRAN: Anyone who has visited the Lexington Institution cannot help but be very much impressed with the fine facilities they offer to addicts. These facilities together with the beautiful surroundings in which the institution is placed, must have a beneficial result.

The inmates that I saw and talked to, both prisoners and volunteers, appeared to be busy, happy and contented. There is an extensive work program which Dr. Isbell explained, and I was very much impressed with the beautiful work turned out in their furniture operations and also by the fine quality of clothing in their clothing factory.

While Lexington is what is called a "Security Institution" they explained that their security problem was directed rather to keeping drugs out than the need to keep the inmates in. There are a small number of runaways or escapees, but Dr. Isbell said there is usually some reason for this.

For example, an inmate receives word that his wife or woman is running around with another man and he becomes anxious and wants to get out and straighten the matter out himself. Again, an inmate may be wanted for another offence and he may find it convenient to leave a few days prior to his release in order to avoid being picked up on another charge.

I asked Dr. Isbell something of the problem of smuggling drugs and I gather that while drugs can find their way in, it is fairly easy for the authorities to know when this has happened. Addicts are notorious for talking about drugs and word would quickly get around if an addict were getting drugs from outside and apart from this, it might well be apparent in his general

attitude. The security problem, therefore, is one that has to be carefully watched, but I did not gather that there was any likelihood of drugs being available in an institution without the authorities quickly becoming aware of it.

The property is wholly fenced, but this would not prove any insuperable difficulty to a patient who wanted to escape. The food which they get is of the best and the recreation facilities are as fine as could be imagined.

For example, they have a beautiful auditorium in which moving pictures and amateur theatricals are put on. They have a number of bands organized by patients. They have a nine-hole golf course which the patients may use. They have baseball teams, television and other attractive forms of recreation. I should say that there is, of course, very strict segregation between the male and female patients.

Senator BAIRD: There are two such institutions in the United States?

Mr. CURRAN: Yes.

Senator BAIRD: Do the "voluntary inmates", as we might call them, come from far away?

Mr. CURRAN: There is a dividing line there. Fort Worth takes care of one side of this line and Lexington takes care of the other.

The night that I arrived at the Institution I learned that there had been four people arrive asking for admission on a voluntary basis. I saw them all and spoke to one or two the next day during my visit to the withdrawal ward of the hospital.

The admitting procedure was explained and it is very strict in so far as the possibility of smuggling drugs in is concerned.

The patients are searched at the admitting office and warned to surrender any drugs or narcotic paraphernalia which they may have in their possession. They are warned that if they do not do so they can be charged with the offence of smuggling drugs into a federal institution.

They are then put in the withdrawal ward for a period of 72 hours during which time they receive some medication for their symptoms. After a further period in the withdrawal ward, they are put in the convalescent section for a matter of some five or ten days, so it may be roughly twenty days after a patient arrives at Lexington before he is received into the institution for treatment as divorced from the medical side of the operation. That is not an inflexible period, but I think it is roughly an average. The discomfort with individuals depends upon the severity of the habit.

I spoke to two or three, and the Committee may be interested in what I found out.

One coloured boy who told me that he was a bellhop in Chicago, had come the night before as a voluntary admitting. He told me that his habit had been a total of 9 "caps" per day, taken 3 at a time. I asked him the price that he paid and he said \$1.00 per "cap" and he admitted that he thought the quality was pretty weak to be selling at that price. Presumably this man had a very mild habit because he did not show any number of scar needle marks, nor was he under any great discomfort the following afternoon.

In contrast to him, I saw another coloured man who had also arrived the night before. This man was quite ill. He was vomiting. He had severe cramps. He was not talking normally. His skin was cold and clammy, even though it was an extremely hot day. Obviously he had been heavily addicted and the withdrawal symptoms that he displayed certainly were detectable even to a layman, and obviously were giving him great discomfort.

Senator HORNER: I think Dr. Isbell told us they gave some mild withdrawal doses?

Mr. CURRAN: They use a drug called "methadone" for withdrawal. This is administered in accordance with the individual's particular needs.

The doctors can look at an individual during withdrawal and decide from his then symptoms whether he is following the usual withdrawal pattern or whether he is a little sicker than they expect at that particular time.

The withdrawal is intended to relieve severe distress but not to keep the man as happy or comfortable as he would be when under the influence of drugs. The dosage, therefore, apparently has regard to known withdrawal procedures which on experience, follow a fairly uniform pattern.

Senator HORNER: I think Dr. Isbell told us they gave some mild withdrawal doses?

Mr. CURRAN: I think they use a drug called "methadone", and they sustain them with methadone. The doctor looks at a man, and he may say, "The man is a little more sick than he should be at the present time", and therefore he is given some medication to relieve the extra symptoms. This has regard to known withdrawal procedures which follow a fairly uniform pattern.

Senator MCINTYRE: Do they get free treatment at this institution?

Mr. CURRAN: It is financed by the federal government. They are supposed to pay if they can, but very few ever do pay. Some of the professional men who are in there on a voluntary basis might pay their own way.

Senator BEAUBIEN: Did you secure any evidence about enforced isolation of these people? Did you receive any impression in regard to that in the United States?

Mr. CURRAN: The impression I secured when going to Lexington was that you have to have isolation of the addicts, to keep them away from access to drugs. You have to have complete isolation, otherwise drugs will find their way in. Secondly, you must have a reasonable control over the person while he is in the institution, and, thirdly, there should be some parole system to follow up those who are released, to endeavour to make sure they will not get right back on to the habit when released.

Senator HORNER: And, if they think desirable, they can hold them a little longer.

Mr. CURRAN: Supervise them on parole after they get out.

The CHAIRMAN: Honourable senators, are there any further questions to ask Mr. Curran?

Senator BEAUBIEN: I think Mr. Curran has given us a very, very fine resume of the whole situation. I want to congratulate him for that.

Mr. CURRAN: Thank you, Mr. Chairman and Senators.

The CHAIRMAN: Our next witness is Dr. L. P. Gendreau, Deputy Commissioner of Penitentiaries. I will ask him if he will now come forward.

Dr. L. P. GENDREAU, *Deputy Commissioner of Penitentiaries*.

The CHAIRMAN: Will you please proceed, Dr. Gendreau.

Dr. GENDREAU: Mr. Chairman and honourable senators.

I wish to make it plain at the outset that adduced facts and figures on drug addicts appearing in this paper are based upon the study of penitentiary inmates, and pertain to them mostly. Offenders who are awarded a sentence of two years and over become inmates of the penitentiaries; those awarded less than two years are held in prisons, reformatories, industrial schools or

other institutions of similar kind administered by the respective departments of the Provincial Attorneys General.

The number of inmates sentenced for violation of present narcotic laws is as follows, for each penitentiary:

Dorchester	7
St. Vincent de Paul	23
Federal Training Centre	0
Kingston—Male	73
Female	44
	117
Collin's Bay	0
Manitoba	23
Saskatchewan	22
British Columbia	177
Total in Penitentiary	369

The CHAIRMAN: Is that for last year?

The WITNESS: That is a figure as of the first of June.

The seven addicts presently incarcerated at Dorchester, N.B., include four transferred from St. Vincent de Paul.

There are 44 female inmates addicted to drugs out of a total of 89 held at the Prison for Women at Kingston. The great majority of these come from British Columbia.

It is generally assumed by most people that the so-called drug addict is a person who at first takes drugs, later develops a habit for such and in time becomes unable to control himself. It has been felt that in dealing with him all one has to do or could do is to prevent the drug from reaching him or remove him from the possibility of obtaining such drugs for a certain period of time. In practice, it seems that this procedure has reduced the incidence of drug addiction, but has not done away with the problem. In referring to someone as a "drug addict", we describe the deed mostly, that is, the addiction, and tend to forget or overlook what is the most important constituent of the whole picture, which is that the deed has been committed by a person. The common practice, consisting of describing an offender by his deed, is a misleading one. The terms, "thief," "rapist," "forger," are frequently used and all give the impression that the term describes completely the offender.

A medical practitioner would not think of describing a case of pneumonia as being a case of "pain in the chest" or one of "fever" or "frequent cough," for he would be merely mentioning symptoms, but he would rather attempt to be descriptive of the whole individual and state that:

Pneumonia has developed in a person 65 years of age, who is in a state of mental depression, whose general physical condition is and has been poor due to a severe heart condition which has been in existence for the past year and has not responded favorably to prescribed treatment.

In so doing, he describes the total picture and it is only through his comprehension of the various components which make up this man's illness that he can hope to achieve better success in treatment. It should be taken that criminal behaviour is symptomatic of personality and still more specifically of emotional disturbance. The disturbance may manifest itself through various deeds which may be generally referred to as "antisocial deeds."

Examination of the files of 150 so-called drug addicts reveal the following facts and figures in relation to what has just been said:

Dr. GENDREAU: In regard to Table I: I will not read the whole thing, because it is fairly obvious that in all of these cases you have the sentence prior to the time the drug addiction is admitted.

As you go down the list you will see that all jail sentences meted out to these offenders, and even a number of penitentiary sentences meted out prior to their addiction, so I think that shows quite well that many of these individuals were of a personality which made it quite possible for them to become anti-social and drug addiction was a symptom of their personality.

On page 3 you will see the record of these men. If you look at the class of crimes committed, you will see the crimes against property, and very seldom crimes against the person. There is one case, No. 84, which shows a man did receive a jail sentence plus lashes, for the offences of grievous bodily harm, robbery with violence. However, that is the exception, rather than the rule.

The CHAIRMAN: As a rule they are not violent criminals?

Dr. GENDREAU: As a rule, no.

Senator BEAUBIEN: They all had records before?

Dr. GENDREAU: Yes, as shown on pages 3 and 4, and so on, down to page 5, which includes the 150 cases which have been studied.

TABLE I

(The following shows sentences prior to the time at which drug addiction is admitted in each case)

	<i>Indust'l</i>	<i>Jail Farm Reform. Pen'y</i>	<i>Crimes</i>
1.			Nil
2.		1	Theft
3.	4		Theft, Vagrancy, B & E, Escape
4.	1		Theft
5.			Nil
6.	2	1	Procuring, Stealing, Fighting
7.	6		Juv. Ct., Steal Auto, Common Assault, Retaining, Damage to Property, Driving to Common Danger
8.			Nil
9.	1		B.E.T.
10.	1		Theft
11.			Nil
12.			Nil
13.			Nil
14.	1		Shopbreaking and Theft
15.		1	Truancy
16.			No record
17.	2		B.E.S., Stealing
18.			No record
19.			No record
20.	1		Vagrancy
21.			No record
22.	4		Theft (3), B & E
23.	2	1	Stealing, B.E.T., Theft
24.	3	1	Vagrancy, Theft, Stealing, B.E.T.
25.			No record
26.			No record

<i>Indust'l</i>				<i>Crimes</i>	
<i>Jail Farm Reform. Pen'y</i>					
27.				Nil	
28.				Nil	
29.				Nil	
30.				Nil	
31.	1		1	Possess Drug, Vagrancy	
32.	1			Vagrancy	
33.	2		1	Forgery, Poss. Revolver, Auto Theft	
34.	2			Attempt auto theft, Theft	
35.				Nil	
36.	2			Shopbreaking & theft, Shopbreaking	
37.	1	1	3	Shopbreaking (4), Receiving	
38.	1	1		False Pretences, Theft	
39.				No record	
40.	3		1	Auto Theft, B.E.S., B.E.T., Take Auto	
41.		1	1	Theft, Poss. Burglar Tools	
42.				No record	
43.	9		2	Vagrancy (3), Burglar Tools (2), Theft (2), Forgery, ONDA, L.C.A.	
44.				Nil	
45.				Nil	
46.	1			B.E.T.	
47.				No record	
48.				No record	
49.				Nil	
50.				Nil	
51.				No record	
52.	1			Attempt auto theft	
53.	1			Possess burglar tools	
54.	2			Theft (2)	
55.	3			Gross Indecency, Auto Theft, Theft	
56.	4		3	Vagrancy, Theft (2), B.E.T., Disorderly conduct, Possess Drugs, Violently steal.	
57.				No record	
58.				No record	
59.	3			Theft, Vagrancy (2)	
60.				Nil	
61.				No record	
62.				No record	
63.	1			Possession of stolen goods	
64.	5			Shopbreaking & Theft, Theft (3), S.E.T.	
65.				No record	
66.	1			Attempt auto theft	
67.				Nil	
68.				No record	
69.				No record	
70.	3			Att. Shopbreaking, Att. auto theft, Retaining stolen goods.	
71.				No record	
72.	1			Theft of auto	
73.				No record	
74.				No record	
75.	6	2		Vagrancy, Auto theft, Poss. firearm, Drunk (4), Assault, Inmate of Bawdy house.	

76.			No record
77.			No record
78.			Nil
79.			No record
80.	2		Assault, Theft
81.	5	3 1	False Pretences (3), Theft (3), Take auto, Retaining stolen goods.
82.		1	Retaining
83.	1		B.E.T.
84.	2 plus lashes		Grievous bodily harm, Rob. Violence
85.			Nil
86.	2	1	Bodily harm, Assault, Theft w. Viol
87.	1		False pretences
88.			Nil
89.	5	1	Auto theft, False pretences, B.E.T. (2), B.E.W.I.S., Escape
90.	6	2	B.E.T. (2), Auto Theft, Poss. Stolen prop. (2), Burglar Tools, Escape (2)
91.	4	1	Theft (2), B.E.T., Steal Auto, Retaining
92.			Nil
93.			No record
94.	1		False pretences
95.	2	1	Auto Theft (2), Robbery w. Violence
96.			Nil
97.	1		Assault peace officer
98.	1		Auto theft
99.	7	1	False Pretences (3), Forgery (3), Mann Act, Illegal entry.
100.			Nil
101.	3		Theft, Assault, Wilful damage
102.	3		Theft (3)
103.			Nil
104.	5		Theft, Shoplifting, Auto Theft, B & E, Found in dwelling house.
105.	1		B.E.S.
106.	12	1	Vagrancy (2), Stealing, Auto theft, Att. B & E, Theft (5), Retaining, Procuring a prostitute
107.			Nil
108.			Nil
109.	1	1	Robbery, Possess Cocaine
110.	5 1	1	Theft, Stealing, Vagrancy (2), False Pretences, Assault, Br. L.C.A.
111.	3	2	Assault, Theft, Assault w.i. Steal, Assault peace officer, B.E.W.I.
112.	2		Shopbreaking w.i., Theft
113.	1		Steal auto.
114.			Nil
115.	3	1	B.E.T., Auto Theft (2), Escape
116.			Nil
117.			Nil
118.			Nil
119.			Nil
120.	1	1	Larceny, Theft
121.	1		B.E.T.
122.			Nil

	<i>Indust'l</i>		<i>Crimes</i>
	<i>Jail</i>	<i>Farm Reform. Pen'y</i>	
123.	3	1	B.E.T. (2), Housebreaking, Theft
124.	4	2	Theft, Poss. Stolen Property, Auto theft, B.E.T. (2), Forgery
125.	3		B.E.T., Housebreaking, Auto theft
126.	6	1	B.E.T., Viol. Steal (2), Escape (2), A.O.A.B.H., Steal auto.
127.	1	1	Steal auto (2)
128.			No record
129.			No record
130.			No record
131.			Nil
132.	8	2	Retaining (2), Poss. Drugs (3), Rob. Violence, Vagrancy (2), Theft (2)
133.			No record
134.			No record
135.	2	2	Rlwy Act, Viol. Steal, Rob, Violence, Common Assault
136.	3	1	Att. Auto theft (2), Theft, Vagrancy
137.			Nil
138.	7		B.E.T., Theft (2), Auto Theft, Assault police officer, Skip bail, B & E
139.	1		Theft
140.		1	Armed bank robbery
141.			No record
142.	4	1	Theft, Violently Steal, Theft of Auto (2), Vagrancy
143.	1		Robbery
144.			Nil
145.	2		B.E.T., A.O.A.B.H.
146.			Nil
147.			No record
148.			No record
149.			No record
150.			No record

Summary

History of crimes before drug addiction admitted.....	79
No crimes before drug addiction admitted.....	35
No record (commencement of addiction not known).....	36

150

The summary shows that 79 drug addicted penitentiary inmates out of 150 had started and had remained antisocial to the extent that jail and penitentiary sentences had been meted out to them; as far as is known, only 23.3 per cent became addicted before they became entangled with the law.

TABLE II

Drug addicts under present study were convicted for the first time at the following ages: 1 at the age of 11 years; 2 at the age of 12 years; 0 at the age of 13 years; 6 at the age of 14 years; 11 at the age of 15 years; 17 at the age of 16 years; 11 at the age of 17 years; 24 at the age of 18 years; 26 at the age of 19 years; 12 at the age of 20 years; 11 at the age of 21 years; 6 at the age of 22 years; 0 at the age of 23 years; 4 at the age of 24 years; 4 at the age of 25 years; 2 at the age of 26 years; 1 at the age of 27 years; 2 at the age of 28 years; 2 at the age of 29 years; 1 at the age of 30 years; 1 at the age of 32 years; 1 at the age of 35 years; 1 at the age of 38 years; 1 at the age of 42 years; 1 at the age of 48 years.

In addition, there are three whose age at first conviction is not known.

Senator GERSHAW: Where do these children get drugs, at that age?

Dr. GENDREAU: They were mostly cases situated in British Columbia, but some came from Saskatchewan. The great majority came from British Columbia.

Senator GERSHAW: Do they go out and get it illegally?

Dr. GENDREAU: Oh yes, from illegal sources, as far as I know.

Senator BEAUBIEN: Do these young addicts come under your jurisdiction?

Dr. GENDREAU: Eventually, but when we studied their past histories, we got the information as it is recorded here.

They were not in the penitentiary at that age. They were convicted of certain offences, but not drug addiction.

The CHAIRMAN: I want to make that clear, because when I heard of this, I thought that people of younger ages were convicted of drug addiction, but Dr. Gendreau says that is not the case; that they were convicted for other crimes.

Senator LEGER: They were convicted for crimes when they were young, and became drug addicts later on?

The CHAIRMAN: Yes. I thought I should correct the impression that they were young addicts. They were not; they were convicted for crimes other than addiction.

Those under study were not addicts at the time of their first conviction. Drug addiction became part of the picture at a later age, as shown below:

For those whose first offence was recorded at the age of 14, drug addiction was admitted at the following ages: two at 16, 1 at 17, 1 at 19, 1 at 21, and 1 at 26.

Of the eleven first convicted at the age of 15, drug addiction was admitted at the following ages: 1 at 15, 1 at 19, 1 at 20, 1 at 22, 1 at 23, 2 at 24, 1 at 28 and 3 not recorded.

For those whose first offence was recorded at the age of 16, drug addiction was admitted at the following ages: 1 at 13, 1 at 14, 2 at 16, 2 at 17, 1 at 18, 4 at 20, 2 at 22, 1 at 23, 1 at 27, 1 at 28 and 1 not recorded.

Senator HORNER: It would appear that some of those whose first offence was recorded at the age of sixteen were drug addicts? But that is not the case; they were first convicted for crimes at the age of sixteen?

Dr. GENDREAU: That is right.

Senator HORNER: This shows, in that connection, that there was one who was an addict at the age of thirteen.

Dr. GENDREAU: That is exactly what this shows.

For those whose first offence was recorded at the age of 17, drug addiction was admitted at the following ages: 1 at 17, 3 at 18, 1 at 20, 1 at 21, 1 at 28, 1 at 31, 1 at 36 and 2 not recorded.

For those whose first offence was recorded at the age of 18, drug addiction was admitted at the following ages: 1 at 13, 3 at 18, 3 at 20, 3 at 21, 1 at 22, 2 at 25, 1 at 26, 2 at 27, 1 at 30, 1 at 31, 1 at 35, and 5 not recorded.

For those whose first offence was recorded at the age of 19, drug addiction was admitted at the following ages: 2 at 18, 5 at 19, 2 at 20, 3 at 21, 1 at 23, 4 at 24, 1 at 25, 1 at 27, 2 at 28, 1 at 30, 1 at 35, and 3 not recorded.

For those whose first offence was recorded at the age of 20, drug addiction was admitted at the following ages: 1 at 16, 1 at 18, 1 at 19, 1 at 22, 1 at 23, 2 at 24, 1 at 28, 1 at 32, and 3 not recorded.

For those whose first offence was recorded at the age of 21, drug addiction was admitted at the following ages: 1 at 16, 1 at 19, 1 at 21, 1 at 22, 1 at 23, 1 at 24, 1 at 31, 1 at 36 and 3 not recorded.

For those whose first offence was recorded at the age of 22, drug addiction was admitted at the following ages: 1 at 19, 1 at 20, 1 at 27 and 3 not recorded.

For those whose first offence was recorded at the age of 24, drug addiction was admitted at the following ages: 1 at 21, 1 at 24, 1 at 27, 1 not recorded.

For those whose first offence was recorded at the age of 25, drug addiction was admitted at the following ages: 1 at 23, 1 at 25, 1 at 30, and 1 not recorded.

For those whose first offence was recorded at the age of 26, drug addiction was admitted at the following ages: 1 at 23, and 1 not recorded.

For those whose first offence was recorded at the age of 27, one only, the age of addiction to drugs is not recorded.

For those whose first offence was recorded at the age of 28, drug addiction was admitted at the following ages: 1 at 18 and 1 not recorded.

For those whose first offence was recorded at the age of 29, drug addiction was admitted at the following ages: 1 at 13 and 1 at 19.

One first offender at 30 began addiction at 30; 1 at 32 began addiction at 28; 1 at 35 began addiction at 48; 1 at 38 began addiction at a time not admitted; 1 at 42 is not recorded and 1 offender at 48 admitted taking drugs from 58 years of age.

Table II provides further evidence to the foregoing in that convictions were recorded before drug addiction entered the picture and it further reveals that in this series of cases the greatest number of offences was recorded for those between the ages of 15 and 21, which fact is rather significant, not only from the standpoint of custody, but more specifically from that of treatment, for many of these cases are dealt with according to existing legislation for juveniles.

I do not know what facilities exist for the treatment of juveniles—or if they exist, what the extent of their adequacy is—but I would like to stress the point that proper treatment administered early in the disease is more likely to succeed than treatment given five or ten years later.

The second part of this paper deals briefly with the question of proper diagnosis. A basic principle of medical practice is that diagnosis should precede treatment. This applies to mental as well as physical conditions. The treatment of a symptom is not likely to bring about either a satisfactory or a permanent cure. Drug addiction is a symptom of a defective personality, or, as is commonly said, of maladjustment. Effective treatment must therefore be directed at the personality and it becomes necessary to get to know all that can possibly be known about this person. Within the penal system are found individuals who fall into various categories well known to the medical profession, and particu-

larly the psychiatrist. Experience already obtained has shown that the possibility of effective treatment and outlook for recovery differs for those who fall in any of these categories. These main groups are: the mentally defectives, the pre-psychotic, the psychotic, the psychoneurotic, the psychopathic. I feel that it can readily be recognized that if drug addiction occurs in any member of such groups, treatment and the outlook for ultimate recovery is thereby affected; this is particularly the case with individuals who have a psychopathic personality.

Treatment for drug addicted persons should be, at first, purely medical. Illness as the result of abstinence should receive proper attention and treatment. The so-called "cold turkey" method is deserving of condemnation as being a form of brutality. It causes needless suffering, and as a rule tends to create an uncooperative attitude as regards later treatment.

Attention should next be given to general rehabilitative measures such as dietary, vocational and recreational features. Malnutrition and pathological conditions arising from it are a not uncommon finding. This seems to be particularly true of the gastro-intestinal tract. Vocational therapy plays an important part in rehabilitative aspect. A large number of addicts have never developed proper work habits or pattern. Vocational assignments related to any specialized skill they may possess is of value. Recreational measures should be used not only from the standpoint of physical improvement but for the purpose of awakening lagging interest and generally for their socializing importance. The influence of religion, school, library, can all have a very beneficial influence. From the psychiatric standpoint, psychotherapy should be attempted individually or in group therapy sessions.

Psychotherapy, whatever form it takes, must be on a purely voluntary basis. No one can be compelled to accept it and unless the individual recognizes the need for such and arranges for such, it can be of no value. Many drug addicts feel no need for psychiatric assistance and do not want it. The addict has found that heroin and morphine allay his fears and anxiety, his tension and in many instances he is not seeking or not thinking of seeking other means. Older addicts have adopted patterns of hostility, aggressiveness, dependence, avoidance, etc., which have become firmly established and they have no desire for any change. However, there are some who seek psychiatric advice. Individual therapy is time consuming and if therapy was accepted by all those in need of it, there would not be enough psychiatrists to supply the demand.

Group psychotherapy was born out of the disproportion between the number of those requiring treatment and available psychiatrists. As a result of group therapy, an inmate participating in it usually finds his adjustment greatly improved, hostile manifestations disappear, aggressive or dependent behaviour improves, energies are redirected towards more constructive and acceptable purposes.

Individual or group therapy is available in all the penitentiaries except two at the present time. So far, very few drug addicted inmates have made use of it; it is felt that in time greater use will be made of it.

I think I would like to say, out of the text here, that one of the reasons I feel it is not being used at the present time is that the addicts have heard of the possibility of free clinics, and they say, "What is the use of getting treatment, when we will get the treatment we prefer, at no cost to us".

Under present conditions therapy is made more difficult of acceptance through the fact that in all penal institutions one must operate under the contradictory dual concept of vindictive deterrence and reformation which must go hand in hand. An inmate can forcibly be removed to the inside of a jail or penitentiary, but psychotherapy cannot be forced on him.

The treatment of the drug addicted individual could be favourably influenced and made more accessible through the development of a therapy centre, including facilities as described above, for such persons. Admission could be on a voluntary basis or through recognized and interested social agencies. The type and duration of treatment to be left to the discretion of the medical superintendent and staff, and anyone not conforming or wishing to leave, would be considered as having left against medical advice and would then make himself subject to the application of legal sanctions whenever a charge is laid.

In the operation of such a centre, emphasis should be placed on the rehabilitative aspect. The ultimate aim of treatment is to bring about social readjustment. Recidivism is, in greater part, associated with or due to lack of supervision, assistance, advice and counselling by fully trained and competent personnel who should have the full financial support required to carry on their activities.

Looking at the problem at a still greater distance, some thought could be given to the prevention of delinquency through the removal of factors which are operative. This could be an effective way of diminishing the number of drug addicts. However, this is not the purpose of this paper. Mention is made of it because if consideration is being given to the diminution of drug addicts in time, much more work must be done in this area than is being done now. More welfare funds are needed for it appears at the present time that if funds are not spent in this manner, at some later time perhaps a greater amount of money will be required to protect society from those who are working against it.

Senator HORNER: That is a very good presentation.

The CHAIRMAN: Have the honourable senators any questions they would like to ask?

Senator HORNER: We have the evidence that at Oakalla Jail, they handle a large number and they have discontinued any withdrawal treatment; they just let them go through the suffering. Do you think that is the proper thing to do?

Dr. GENDREAU: As a medical man, I cannot condone anyone permitting any person to suffer pain. I think it is an indignity to allow any person to suffer needlessly.

Senator HORNER: On that point, I think perhaps it creates in these people a certain amount of bitterness and hostility against the institution, the fact that they were allowed to suffer.

Dr. GENDREAU: I think you are perfectly right.

I have discussed this with drug addicts, and they have mentioned the fact they were allowed to suffer, and no one seemed to care what happened, and they said, "When you talk about treatment, please forget about me; I am going out, and what I will do, is my own affair".

It has made treatment almost absolutely impossible, and is not the proper way. I believe these addicts, no matter who they are, should be treated in a humane fashion.

Senator BEAUBIEN: These addicts, when they get out of your custody, have been away from the drug for a year or two years? They are sentenced to two years when they go to the penitentiary, are they not?

Dr. GENDREAU: Some of them have been, yes.

Senator BEAUBIEN: What happens to them when they come out of there? Are they cured of the drug?

Dr. GENDREAU: They are free of symptoms of the drug, but their mental state is such, in most of them, that they are still dependent on something. They are people who are maladjusted to life, and they are seeking something. I think—to explain that—we all understand that in this life we all seek pleasure and we all try to avoid pain, and I think fundamentally we are all driving at that. Some people find pleasure in various things—the things they do, the things in which they are useful, the work they are doing for others. But with many addicts, they find pleasure out of not meeting reality. Life is not pleasant for them; they cannot see anything interesting, they cannot face it, it is too much for them, so they seek refuge in something else, and morphine gives it to them.

Senator BEAUBIEN: Of course you give them work in your institution, do you not?

Dr. GENDREAU: They will work—not too hard, and they are not too inclined to do it, but they will do it; but when they get out, we know the story.

Senator HORNER: From your experience of handling addicts have you some hope that a percentage are cured, that they discontinue after having once become addicts?

Dr. GENDREAU: According to the files, I have been following a few. I think I have five or six that have not returned. What they are doing I don't know. I think at one time when there was a discussion about starting a Narcotics Anonymous group we were hard put to find someone who had conquered the habit. I was in touch with Mr. Hossick about this, and with the people at the coast, and they could not with certainty say to me, "Here is a man who has conquered the habit". But lately in Montreal, people who never had a jail sentence, and were supposed to be addicted, have offered their services, and they want to go in the penitentiary to start a Narcotics Anonymous. I heard that one of them is a medical man. I don't know who the others are. Of course they want to remain anonymous, and until I meet them personally I don't know who they are.

Senator BEAUBIEN: You think there is some hope in Narcotics Anonymous?

Dr. GENDREAU: Narcotics Anonymous, like Alcoholics Anonymous, is a form of group therapy, and a most valuable form. It stemmed out of the fact that people who have similar problems, when they can get together and discuss their problems, feel better. It is one characteristic of the human being; we are all like that; and inmates of the penitentiaries are like that. Put them in a group, let them discuss their problems. They blow off a lot of steam, and say a lot of awful things about everybody, but afterwards they settle down and feel better. They get rid of their hostility and aggression, they talk it out, and they are better for it. It is a simple thing, and it can be done provided you have a skilled staff to handle it.

The CHAIRMAN: Any other questions, honourable senators? If not, we thank you most sincerely, Dr. Gendreau, for your presentation. Inspector Atherton, will you kindly come forward? . . . You may proceed.

Inspector J. J. ATHERTON (*Royal Canadian Mounted Police*): Mr. Chairman and honourable senators, I have been asked to speak on the subject of ship and border searches in relation to the illicit drug traffic.

Possibly I should mention that I have been in the Mounted Police for twenty-two years, and thirteen of those years were spent in narcotic enforcement work in Vancouver. I was in charge of the branch there from 1948 to 1951.

Up to 1942 Vancouver was the principal port of entry for opium into Canada. Opium was the favoured drug until that time and the traffic was controlled by Chinese criminals, many of them resident in Canada.

The opium was generally smuggled into Canada through various British Columbia ports although some was landed on Canada's Eastern seaboard.

The common practice in those days was to hide the opium away in some reasonably safe place on ships which were destined to call at Canadian ports and it would be accompanied by a guard who was generally a member of the crew. It was his job to get the drug ashore at a chosen port and contact the Canadian drug dealer.

The smugglers proved themselves quite ingenious by their choice of hiding places and it was often obvious that an efficient organization was involved as opium was found concealed in a great many places to which only a limited number of people have access. For instance opium has been found concealed behind hardwood panelling in the first class cabins of passenger vessels, in unused steam boilers, in locker rooms, under tons of coal in the bunkers, in portions of the ship's rigging, in hollowed out furniture, in the deck machinery, in life boats and life belts and in many other places including, of course, and very often, the cargo.

There were cases in which cans of opium were tied inside barrels of oil and in cans of food stuffs. It could be in passengers' baggage specially prepared for the voyage with false sides and bottoms.

You will realize then that the chances of finding the drug on a ship without previous information were very slim indeed. This is even more apparent when you consider the overall bulk of a large passenger vessel, and that in it every room, cabin, wall, floor, cupboard, every large piece of furniture, the furnaces and engine rooms, the ventilators and the giant holds all could hide a large quantity of the drug.

When a drug was concealed in baggage it came ashore in the usual way but when it was secreted on the ship itself it had to be removed from its hiding place and either carried ashore by a crewman, or a confederate, or dropped into the harbour to be retrieved by a confederate.

It was sometimes bought ashore with the ship's laundry or the garbage and very often on the person of a crewman or his shore contact. Special vests were used to carry as many as 30 tins of opium and the wearers did not appear to be unusually bulky.

Sometimes the opium was tied to floats and dropped overboard at a pre-arranged point outside of the harbours to be picked up later by confederates in small boats.

The many methods used were much too numerous to be mentioned here.

During these days, prior to 1942, a joint effort was being made by Canada Customs and the R.C.M.P. to combat the smuggling and every ship that could be considered suspect was searched. Customs and R.C.M.P. search squads often boarded ship miles at sea and commenced searching and often an R.C.A.F. aircraft with an R.C.M.P. observer hovered above the ship to see that nothing was dropped overboard.

Obviously it was not possible to give such attention to every ship nor always to all ships arriving from the Orient where the opium originated and it was only through experience, under world contacts and outside information that certain shipping lines or individual ships became known as opium carriers or at least were suspected to be carriers.

In addition to the searches of suspected vessels these ships were carefully watched in port by the customs officials at the dockside and also by plain clothes members of the R.C.M.P. who watched from a distance. Crew members and ships visitors were watched for any action that might indicate smuggling and often searched as they left the ship or as they left the dock.

These operations paid off occasionally but in spite of the combined efforts of the two agencies it is obvious that very large quantities of the drug got through.

Around 1935 a vessel in New Westminster Harbour, about to leave port, pulled up its anchor and with it over a hundred pounds of opium which had been dropped overboard from another ship.

In 1947 the Netherlands vessel, the "Manoeran" was in dry dock in North Vancouver for refitting. A workman, in dismantling a deck crane, found a cache of 165 pounds of crude opium in its base. He called the R.C.M.P. Drug Squad who dispatched a search crew immediately.

Another 208 pounds of opium was then found in the base of a second crane. This was probably the largest seizure of opium ever made in Canada, at least on board ship, and it was found by accident.

In the ensuing investigation it was learned that the opium had not been destined for Canada originally. The ship's captain while en route from Calcutta, India, to a West Coast port of the United States, had been instructed by the owners to put into Vancouver for an overhaul.

The investigation showed that the opium had been put on board in Calcutta for delivery to a Chinese-American drug syndicate in California and that two crew members, unknown to the owners, or ships officers were in charge of the shipment.

The persons involved in Calcutta and California were identified but unfortunately there was insufficient evidence available to justify a prosecution in Canada of the two crew members. However, the results of the investigation were passed on to the U.S. and Indian authorities. The latter were unable to charge the suspects in that country with the export of opium but I understand they were able to break up the operation of the syndicate.

This case was quite unique inasmuch as opium was not being used in Canada at the time and it was then unusual to see any sizeable quantity of the drug in this country.

Earlier I spoke of receiving information about smuggling operations. I was referring to the information received from under world sources in Canada and from bulletins issued by the Narcotic Division of the League of Nations and later United Nations and also from bulletins issued by the United States Bureau of Customs and the Bureau of Narcotics.

In December, 1941 commercial shipping between Canada and the Orient came to a halt with the entry of Japan to World War 2 and the flow of opium stopped.

I have been speaking primarily about conditions on the West Coast with which I am more familiar but similar operations were being conducted on the East Coast.

I have also been speaking of the pre-war period and I should mention that with the resumption of commercial shipping in the Pacific so did the activities of the Canada Customs and the R.C.M.P. resume.

Search crews board incoming vessels regularly on both coasts and when there is any suggestion of drug smuggling the search crews are augmented with additional staff.

For a time after December, 1941 we were plagued with drug thefts. Every drug store, hospital, drug manufacturing house and doctor's office was a mark for addicts and their suppliers. In Vancouver it was so bad that the Vancouver Police and the R.C.M.P. had flying squads patrolling the drug stores and hospitals by night and by day investigating successful thefts. I can say that a measure of success was attained in bringing the culprits to justice but there was no lessening in the numbers of addicts.

Soon opium and later heroin found its way to Canada from Mexico via the U.S. but by this time control of the market had changed from the Canadian and American Chinese to non-addict Canadian and U.S. gangsters on the Eastern side of this continent.

The drug now was being smuggled into Canada primarily through Eastern Canadian ports so may I now turn to the problem of searches at border points.

As you are aware there is a vast number of automobiles crossing the border at a multitude of places every day. A table of automotive traffic in Canada at a few of the ports is attached to my statement, copies of which you have. (*See Appendices W and X.*) Again I must say that previous information is the only effective means of finding even a small percentage of the drugs at border points.

I have searched cars on many occasions and know from actual experience that to find even a few ounces of heroin in a car that is known to be carrying it can take hours of search. The drug can be concealed in tires and even inside the tubes, behind portions of the upholstery, in hidden compartments anywhere on the car, in the gas tank and in one case at least it was hidden in an engine cylinder from which the piston had been removed.

It would be quite impractical to attempt the search of every car and ship entering Canada and indeed it would obviously require the full time services of thousands of experienced men. Also one must consider the decided impact that such involved searches would have on the Canadian tourist business.

You will note in the prepared tables that in July, 1954, Fort Erie alone admitted over twelve thousand cars daily and in March of this year over two thousand each day.

Again might I speak of international co-operation in the matter of drug smuggling. In every case, where there is an indication of smuggling between Canada and the United States, enforcement agencies of each country contact their opposite number in the other.

I should mention certain cases where such co-operation resulted in arrests and the seizure of drugs. In Vancouver the R.C.M.P. became aware that a local distributor was about to take delivery of a quantity of heroin in Seattle. The drug was to be delivered to him in that city from New York. Members of the R.C.M.P. went to Seattle, contacted Federal Bureau of Narcotics agents, advised them of the plan and identified the suspect. As a result he was arrested by the U.S. officials in Seattle shortly after he took delivery of the heroin. The drug of course was seized.

Later the same agents learned of an alleged plan to smuggle heroin from Vancouver to Seattle. They went to Vancouver and in conjunction with the R.C.M.P. continued the investigation. It led the way to George and John Mallock who were eventually arrested and charged with one of their hirelings.

In still another case the R.C.M.P. became aware that a Portland man intended to bring a quantity of heroin to Vancouver. He was apprehended at the Patullo Bridge at New Westminster while en route. A small quantity of heroin was seized on that occasion and his new Cadillac car was seized and forfeited. There is a constant flow of information between the U.S. enforcement agencies and the R.C.M.P. and there is also a very close liaison in connection with the international movement of illicit narcotics through the International Criminal Police Commission.

The cases I have mentioned are isolated and though they have their place in the overall field of drug investigation and enforcement with border and ship searches they have not lasting impact on the traffic other than a slight deterring effect. The arrest of a group of smugglers or traffickers just makes way for another group which is attracted by the huge profits. Such searchers do not show the way to a reduction in the traffic or the elimination of addiction.

The CHAIRMAN: I note with regard to your chart on automotive traffic into Canada, for the province of British Columbia you show Pacific Highway as a custom port. As you know, there are two ports of entry, Douglas and Pacific Highway, and I would judge that there is ten times the amount of traffic through Douglas as there is through Pacific Highway.

Inspector ATHERTON: That is right. I think that when this was being prepared for me they included the entries at Douglas.

Senator HORNER: What about Prince Rupert? Do any ships call there directly from the Orient?

Inspector ATHERTON: There are some calling there at the present time. There were quite a number calling there during the opium days, of course.

Senator HORNER: I read an article in connection with the work done by a Senate Committee in the United States. Blame was put on the over-production of drugs in the world. It pointed out the difficult task confronting the authorities because of the huge surplus. I wonder if some international arrangement could not be made where a closer check could be made? What is the situation, for instance, with regard to Russia?

Inspector ATHERTON: I have no idea at all, sir.

Senator MCINTYRE: According to this paper, a very small percentage of this drug is captured by the R.C.M.P. officers. Have you any idea what the amount of the percentage is?

Inspector ATHERTON: All I can say is that it would be very low. It would be possible of course to estimate the annual amount used by the addicts in Canada, by getting a general figure, possibly, and putting that against the amount actually seized, and thereby arriving at some kind of a figure, but I know it would be very low, anyway.

Senator BEAUBIEN: Where is heroin produced, in the Orient?

Inspector ATHERTON: I am not prepared to say at the moment, because I have not been connected with the traffic for the last three years.

Senator BEAUBIEN: Is it produced in many countries, do you know? Are you able to answer that, Mr. Chairman?

The CHAIRMAN: Well, Mexico and China are the two countries, and then there are some continental countries that produce heroin as well. Is the changeover to heroin from opium more difficult in the matter of detection?

Inspector ATHERTON: I think it is probably a little more difficult now than it was in the case of opium. Certainly at the time when people smoked opium it was not too difficult to find people in possession of opium for smoking.

The CHAIRMAN: Have you any information as to where heroin is coming in from, Mr. Hossick? Perhaps you could answer Senator Beaubien's question?

Mr. HOSSICK: As a matter of fact, Mr. Chairman, it took us about one week of deliberations at the recent sessions in the Narcotic Commission, to ascertain from documentation that there were illicit drugs originating from Lebanon, and according to Mr. Anslinger's statement, as a result of his investigating officers' reports in the Far East there was a large quantity coming from Communist China. As far as we know there are a number of illicit factories operating in Europe, and it has been drawn to the attention of the countries concerned, and they have promised co-operation to try to eliminate this illicit source of supply.

There was one question asked, if I may answer it now, and that is in regard to why do the United Nations not do something to stop the over-production of opium. That was one of the objects of the 1953 opium protocol, which I attended in New York as the Canadian representative, and we feel that that was a step in the right direction, to try and control production to world needs. We know now there is over-production. I understand that at

the present moment the United Nations are considering some assistance from the agricultural assistance organizations to try and develop agriculture in these areas where opium has been grown for centuries. As a matter of fact, most of the producers of opium in some of these areas do not even know what opium is—it is just an article of commerce as far as they are concerned, and the countries where its production takes place have laws and regulations which say that all opium must be delivered to the state monopoly, but as far as we can find out they have no record of the areas actually under cultivation and what the acreage yield may be. I believe, however, that the 1953 protocol—which by the way has been ratified by Canada along with a number of other nations—may be effective in controlling the problem in future.

Senator KING: In those countries where they grow the poppy, the crude opium is not refined there, is it?

Mr. HOSSICK: In some cases it is. In India, for instance, they do refine the opium into alkaloids for their needs, and also some for export, but I do not think the country itself is responsible for the illicit traffic in drugs. It just so happens that in some cases it is conducted illicitly within the borders of those countries, and we hope that effective steps on a national basis will be taken to control that situation when it is discovered.

Senator HORNER: We in western Canada have European people, not far from where I live, and the poppies grown are destroyed and they are prohibited from growing poppies. Now, some of those people from Europe grow the poppy for the seeds, which they put in their cereal and in their bread, but they have been prohibited strictly for years and years from growing poppies to any extent.

Inspector ATHERTON: It does grow in the country and steps have been taken to prevent it being grown, and around this time of the year the mounted police will look around in the localities and see if there is any sign of it growing, and some central Europeans do grow it for seed, as you say. The dried pod of opium will yield a quarter of a grain of morphine approximately, and some addicts have taken the pods, crushed them, but it in water and boiled it, and made what is called opium tea, and that does sustain them in their addiction. It was quite prevalent during the war years when the drug was not so readily available. But I only know of one prosecution for such an offence. People, generally, will co-operate and will destroy the drug when requested to do so.

Senator BEAUBIEN: Is it prohibited to grow the poppy?

Inspector ATHERTON: Yes.

Senator BEAUBIEN: All over Canada?

Inspector ATHERTON: Yes.

The CHAIRMAN: Any other questions? If not I wish to thank you, sir.

Mr. Lief, as counsel, has one or two things to say, and I think that will wind up our morning's session.

Mr. LIEFF: Mr. Chairman, with your permission I would like to read into the record one or two items.

The CHAIRMAN: This is important regarding the statement made by Chief Walter Mulligan about the thefts.

Mr. LIEFF: With respect to the statement that we heard in Vancouver concerning the large dollar value of merchandise stolen from shops. We tried to get information from certain department stores with chains out in the western provinces, and we have just received a letter from Hudson's Bay Company, which I would like to read into the record, because it is of some interest. It is addressed to me as counsel:

HUDSON'S BAY COMPANY
HUDSON BAY HOUSE, WINNIPEG

31st MAY, 1955.

Mr. A. H. Lief, Q.C.,
Committee Counsel,
The Senate,
Ottawa, Canada.

Dear Sir,

This is in reply to your letter of 17th May, and further to our acknowledgement of the 20th May, 1955.

Our six department stores operating in Western Canada have reported the following as their respective known dollar losses of merchandise due to shoplifting during the past twelve months:

Winnipeg, \$8,467.
Vancouver, \$2,767.
Calgary, \$1,793.
Edmonton, \$1,145 plus fraudulent charges of \$523.
Victoria, \$1,662.
Saskatoon, \$67.

The number of known drug addicts apprehended for shoplifting by stores during the past year was as follows:

Winnipeg, 1 out of a total of 221.
Vancouver, 20 out of a total of 285.
Calgary, 1 out of a total of 171.
Edmonton, 1 out of a total of 206
Victoria, 2 in 4 years. Total 177 last year.
Saskatoon, 1 out of a total of 2.

In supplying the above information, we would like to emphasize that the dollar losses reported are only known losses. We realize, however, that actual shoplifting losses are probably many times those reported, but we have no way of knowing what the exact amount might be.

On the other hand, we do know that stock shortages in our six stores totalled approximately \$800,000. These were made up as follows:

Winnipeg	\$230,000
Vancouver	230,000
Calgary	85,000
Edmonton	105,000
Victoria	100,000
Saskatoon	50,000

The Vancouver and Edmonton stores' stock shortage percentage rate to sales equalled the chain average.

Calgary store was 36% lower than the average.

Winnipeg, Victoria and Saskatoon were 18%, 45% and 55% higher respectively than the chain average.

The stock shortages referred to do not include those which occurred in food departments, restaurant departments, and so on. These departments represent 17½% of our total sales volume.

We would like to point out that stock shortages may be due to several factors, the most common being: (a) clerical errors; (b) internal theft; (c) shoplifting.

We trust the above information may be of some help to your Committee.

The CHAIRMAN: That is quite a different story to what we got about the great thefts.

Mr. LIEFF: I should like to say Mr. Chairman that we communicated with another very large department store, and Mr. Curran and I spent some time with some of the officials of that organization but we were not able to convince them to let us have the information.

There is another item which should be of interest to the committee, a copy of a resolution which was given to me by Mr. Hossick, a resolution adopted by the Commission on Narcotic Drugs at its tenth session. This resolution was prepared for presentation to the Economic and Social Council on the Abuse of Drugs. I understand that the tenth session has just terminated.

The CHAIRMAN: That is a Commission within the framework of the United Nations is it not Mr. Hossick?

Mr. HOSSICK: Yes, Mr. Chairman.

Mr. LIEFF: I think the resolution will be of some interest and I want to note a view expressed in item No. 2 of the resolution. It reads: "The Economic and Social Council notes the view expressed by the Commission on Narcotic Drugs that in the treatment of drug addiction methods of ambulatory treatments (including the so-called clinic method) are not advisable."

That is the finding of the Commission.

The CHAIRMAN: That is the United Nations Commission expressing its view against clinical treatment of drug addicts.

Senator KING: That resolution is from what organization did you say?

Mr. LIEFF: It is a resolution adopted by the Commission on Narcotic Drugs at its tenth session for presentation to the Economic and Social Council on the Abuse of Drugs. It is part of the United Nations Organization. The resolution reads as follows:

ABUSE OF DRUGS (DRUG ADDICTION)

The Economic and Social Council,

- a. Recalling resolution 548 I (XVIII) and the recommendations contained therein.
- b. Noting that in their Annual Reports certain countries have provided statistics of addiction that are of great value;
- c. Recognizing that such statistics and the information regarding the extent and character of drug addiction which they involve are necessary for effective counter measures against addiction;
- d. Noting that the work undertaken by the Social Commission in the field of prevention of crime is parallel in a number of respects with the work of the Commission on Narcotic Drugs,
 1. Requests the Secretary-General to continue to collect information and pursue his studies on aspects of drug addiction in consultation with the World Health Organization, the Social Commission of the United Nations and other bodies concerned;
 2. Notes the view expressed by the Commission on Narcotic Drugs that in the treatment of drug addiction methods of ambulatory treatment (including the so-called clinic method) are not advisable;

3. Expresses its appreciation of the assistance given by the World Health Organization and requests the Organization to prepare:

- (i) an up-to-date study on appropriate methods for treating drug addicts;
- (ii) Information on methods and precautions which could assist the medical profession in prescribing narcotic drugs;

4. Recommends that Governments concerned take appropriate measures

- (i) to establish, if they have not already done so, the necessary arrangements for collecting information on the extent and character of drug addiction in their countries, and
- (ii) to submit such statistics on the lines of the form of Annual Reports as revised by the Commission on Narcotic Drugs.

Senator LEGER: Mr. Chairman, when we were taking evidence at Montreal we heard from a man who wanted to say something in French. He was supposed to make a report direct to you. Have you received that report?

The CHAIRMAN: No.

Senator BEAUBIEN: It seems that his wife was an addict and he wanted to put a proposition before the committee.

The CHAIRMAN: Nothing has come from that source.

Mr. LIEFF: Mr. Chairman, throughout the study that has been made in connection with the inquiry of this committee, we have had the benefit of using a large number of text books, papers and documents obtained either from the Department of National Health and Welfare or from the Library of Parliament. I have a list of the bibliography and with your permission I would like to have it incorporated in our evidence.

The CHAIRMAN: I think that would be satisfactory.
(See Appendix Y.)

Mr. LIEFF: Mr. Chairman, I have here a schedule showing the conventions, agreements and protocols to which Canada is a party, and with your permission I will read it.

The CHAIRMAN: That is agreeable.

Mr. LIEFF: (Reading):

"1912 Convention" for International Opium Convention, signed at The Hague, 23.I.1912.

"1925 Convention" for International Opium Convention, signed at Geneva, 19.II.1925.

"1931 Convention" for International Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, signed at Geneva, 13.VII.1931.

"1936 Convention" for The Convention of 1936 for the Suppression of the Illicit Traffic in Dangerous Drugs, signed at Geneva, 26.VI.1936.

"1925 Agreement" for Agreement concerning the Manufacture of, Internal Trade in, and use of Prepared Opium, signed at Geneva, 11.II.1925.

"1931 Agreement" for Agreement for the Control of Opium-Smoking in the Far East, signed at Bangkok on 27.XI.1931.

"1946 Protocol" for Protocol of 1946 amending the Agreements, Conventions, and Protocols on Narcotic Drugs, concluded at The Hague on 23.I.1912; at Geneva on 11.II.1925; and 19.II.1925 and 13.VII.1931; at Bangkok on 27.XI.1931, and at Geneva on 26.VI.1936.

"1948 Protocol" for Protocol signed at Paris on 19 November 1948, bringing under international control drugs outside the scope of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success on 11 December 1946.

"1953 Protocol" for Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium, signed at New York, 23 June 1953.

The CHAIRMAN: Well, gentlemen, we have heard from all the witnesses that we can think of at the moment. There is the question of printing a permanent record of our proceedings. It has been suggested that we print one volume somewhat along the same lines as the Blue Book on Estimates, and print about 800 copies in English and 200 in French. A printing like that will stand for many years as a record and any organization or institution desiring to read it will have it all in one bound copy.

Senator BAIRD: What will the cost be per copy?

The CHAIRMAN: I have not investigated, but I can find that out before the committee makes a decision. I understand that the type is being kept set-up and they are holding it at the Bureau. I personally think it would be a nice thing to have.

Senator HORNER: There is just one question that I would like to have an opinion on Mr. Chairman. The question is along the lines of the suggestion that we had made to our committee that the non-addict peddler should receive a stiffer sentence than one given to an addict peddler, that the penalty to be meted out to a non-addict peddler should be greater than that given to an addict peddler who does it for the purpose of supplying his desires for the drug.

I wonder if the representative here of the Mounted Police has any comment to make on that.

Inspector ATHERTON: Mr. Chairman, I really do not know if I am qualified to speak on the matter of sentences to be given to traffickers, but I think that it is obvious that the man who was not addicted to the drug himself is deserving of more severe penalties. Nevertheless, he is not creating any more addiction than the addict peddler. If you think of it in terms of how much harm he is doing he is not doing any more harm than the addict peddler, but if you think of it in terms of rehabilitation, peddling by a person who is not an addict is reprehensible, and he should get a heavy penalty for doing so. But I think we have to consider both sides of it and consider the amount of harm he is doing.

Senator LEGER: May I ask, Mr. Chairman, that Mr. Hossick tell us what he thinks about that.

Mr. HOSSICK: When the Narcotic Drugs Act was amended last year it was generally felt in the Committee at that time that there should be an upward revision of penalties for traffickers and those engaged in traffic, and that that would be a step in the right direction. It was felt also that a sufficiently long period should be given to try out the effect of this legislation before any further changes were made.

I think the evidence which has been given before the Senate Committee, Mr. Chairman, has been very very good indeed, and I am quite sure that arising out of that evidence you will probably have some recommendations to make in the handling of the addict population.

At the moment I would hesitate to say anything as to whether those sentences are adequate or not. The law has only been in operation for some nine months now and I think we are making out very well at the moment.

Senator LEGER: We had a man before us who said that if you do away with the addicts you will do away with the peddlers. What do you think?

Mr. HOSSICK: I would not care to venture any opinion in that regard.

Senator BEAUBIEN: In Vancouver we got some evidence—I think it was from one of the magistrates—that in his opinion the Opium and Narcotic Drug Act should be strengthened, and the penalties made much more severe.

Senator BAIRD: Make the penalties fit the crime!

Senator BEAUBIEN: You are of opinion that we should carry on as we are now doing, for the time being?

Mr. HOSSICK: As a matter of fact, senator, I had a conversation with that particular magistrate some time ago, and he appeared to be very well satisfied with the additional sentences which had been included in the Act. I still will go along with much more severe sentences for any type of narcotic traffic.

The CHAIRMAN: Honourable senators: may I say that we were promised from Montreal to be presented with a brief from a Catholic institution down there. Have I your permission that, when it comes, we shall attach it to our records?

Hon. SENATORS: Yes.

The CHAIRMAN: May I say that we are now working on the report, and just as soon as we can we shall call the committee together in session, without the press, and they will deal with the report, and I would expect that not later than the end of the next week we will have the report ready for presentation. May I ask each and every one of you honourable senators that, until our report is presented to the Senate, this matter shall be treated as secret? The press is very anxious to obtain information about what we intend to report, and I have had to tell them right along that I have nothing to give. So I ask every honourable senator to respect secrecy in this matter. We stand adjourned at the call of the Chair.

Senator BEAUBIEN: Is it your intention to present a final report?

The CHAIRMAN: Yes.

Senator BEAUBIEN: Not an interim report?

The CHAIRMAN: No.

APPENDIX A

TOTAL ADDICT POPULATION* BY CLASSES

Province	Criminal	Medical	Professional	Totals
British Columbia.....	1,101	46	38	1,185
Alberta.....	141	32	20	193
Saskatchewan.....	45	11	23	79
Manitoba.....	148	12	16	176
Ontario.....	655	188	127	970
Quebec.....	260	171	77	508
New Brunswick.....	2	19	13	34
Nova Scotia.....	12	31	16	59
Prince Edward Island.....		4	2	6
Newfoundland.....		1	1	2
	2,364	1	1	2
	2,364	515	333	3,212

*Prepared from the card index records maintained in the Division of Narcotic Control of the Department of National Health and Welfare.

APPENDIX B

TOTAL CRIMINAL ADDICT POPULATION BY SEXES AND AGE GROUPS*

Age	B.C.		Alta.		Sask.		Man.		Ont.		Que.		N.B.		N.S.		P.E.I.		Nfld.		Totals		Grand Totals
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Under 20.....	7	16	—	2	—	—	—	1	—	3	—	—	—	—	—	—	—	—	—	—	7	19	26
20-24.....	64	49	11	7	—	—	—	2	5	15	3	4	—	—	—	—	—	—	—	—	73	71	144
25-29.....	109	61	—	—	—	—	5	9	31	24	7	7	—	—	—	—	—	—	—	—	164	96	260
30-34.....	104	43	—	—	8	—	7	9	39	27	7	4	—	—	—	—	—	—	—	—	174	92	266
35-39.....	67	38	11	8	2	1	9	—	72	27	13	9	—	—	—	—	—	—	—	—	176	83	259
40-49.....	146	37	26	10	6	1	21	11	114	36	38	21	1	—	2	—	—	—	—	—	353	116	469
50-59.....	57	8	11	1	—	—	18	1	85	10	41	13	—	—	1	—	—	—	—	—	221	33	254
60-69.....	40	1	1	—	—	—	1	—	24	3	9	2	—	—	—	—	—	—	—	—	78	6	84
70-over.....	9	1	—	—	1	—	—	—	1	1	1	—	—	—	—	—	—	—	—	—	12	2	14
Not known.....	199	45	26	8	14	4	43	20	103	35	61	26	1	—	3	—	—	—	—	—	450	138	588
Totals.....	802	299	96	45	38	7	104	44	474	181	180	80	2	—	12	—	—	—	—	—	1,708	656	2,364

Note: Age is taken as in 1954, and not when first addicted or convicted. Some groups are in 10 year intervals.

*Prepared from the card index records maintained in the Division of Narcotic Control of the Department of National Health and Welfare.

APPENDIX C

TOTAL CRIMINAL ADDICT POPULATION* BY OCCUPATION

Occupation	B.C.		Alta.		Sask.		Man.		Ont.		P.Q.		N.B.		N.S.		P.E.I.		Nfld.		Totals		Grand Totals
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Service Occupations.....	67	98	5	7	1	4	4	5	40	49	11	7	1	—	3	—	—	—	—	—	132	166	288
Prostitute.....	—	55	—	18	—	4	9	—	—	24	—	12	—	—	—	—	—	—	—	—	—	122	122
Housewife.....	—	52	—	5	—	—	9	—	—	49	—	12	—	—	—	—	—	—	—	—	—	127	127
Skilled Workers.....	79	8	15	1	2	—	19	—	79	4	19	2	—	—	—	—	—	—	—	—	213	15	228
Clerical and Sales Workers.....	36	10	6	3	3	—	1	1	54	4	11	3	—	—	1	—	—	—	—	—	112	21	133
Labourers/Unskilled.....	162	4	30	1	11	—	22	—	136	4	25	—	—	—	—	—	—	—	—	—	386	9	395
Seamen.....	32	—	1	—	—	—	—	—	1	—	1	—	—	—	—	—	—	—	—	—	39	—	39
Natural Resources Workers.....	100	—	6	—	1	—	3	—	4	—	2	—	1	—	3	—	—	—	—	—	117	—	117
Managerial and business.....	7	1	1	—	1	—	—	—	8	—	1	—	—	—	1	—	—	—	—	—	18	1	19
Entertainment.....	7	—	1	—	2	—	2	—	8	3	15	1	—	—	—	—	—	—	—	—	35	4	39
Professional—Non-medical.....	6	—	—	—	—	—	1	—	5	—	1	—	—	—	—	—	—	—	—	—	13	—	13
Transportation Workers.....	53	—	2	—	—	—	2	—	22	—	5	—	—	—	—	—	—	—	—	—	84	—	84
Unclassified.....	6	1	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	8	1	9
Not known.....	247	70	29	10	17	2	50	20	115	44	89	44	—	—	4	—	—	—	—	—	551	190	741
Totals.....	802	299	96	45	38	7	104	44	474	181	180	80	2	—	12	—	—	—	—	—	1,708	656	2,364

Note: In many cases occupations are shown as different on different convictions. Last given occupation has been shown in most cases.
 *Prepared from the card index records maintained in the Division of Narcotic Control of the Department of National Health and Welfare.

APPENDIX D

TABLE No. 1

R.C.M.P. Narcotic Convictions

Annually Since 1921

Year (Year ending Sept. 30)	Convictions	Year (Year ending March 31)	Convictions
1921	610	1938	155
1922	800	1939	150
1923	506	1940	173
1924	218	1941	176
1925	355	1942	190
1926	280	1943	95
1927	176	1944	151
1928	161	1945	193
1929	266	1946	142
1930	236	1947	238
1931	135	1948	320
1932	178	1949	343
(Year ending March 31)		1950	407
1934	271	(18 month period) 1951	364
1935	184	1952	411
1936	102	1953	381
1937	131	1954	391

The majority of the convictions from 1921 to 1923 were for either smoking or possession of opium, that being the common drug of addiction during those years.

APPENDIX E

TABLE No. 2

Location and Records—Criminal Records

	B.C.	Prairie Prov- inces	Ont.	Que.	Totals
Criminal addicts records examined	1108	219	503	179	2009
Criminal record prior to narcotic conviction	604	152	367	97	1220
Known addicts with criminal but no narcotic record	304	49	56	39	448
Drug conviction prior to Criminal conviction	200	18	80	43	341
(Note—A number of these may have had records as juveniles)					
Criminal addicts known to have moved to B.C. during period under review					276
Of the 2009 records reviewed only the following were of 'teen' age at time of first narcotic conviction.					
Male—under 20	17	1	5	2	25
Female—unler 20	22	-	5	2	29

APPENDIX F

March 30, 1955.

DRUG ARRESTS AND CONVICTIONS—1941-1954

	U/20	20-29	30-39	40-49	50-59	60-69	70/0	Not Stated	Total Arrests	Total Convictions
1941 .....	..	17	23	7	7	1	1	..	56	52
1942 .....	..	5	10	6	4	..	..	..	25	21
1943 .....	..	7	11	10	2	..	..	1	31	26
1944	1	17	23	6	3	1	..	..	51	39
1945	5	16	14	7	4	8	..	1	55	42
1946	4	37	30	21	3	2	1	..	98	61
1947	2	36	44	20	6	3	..	..	111	75
1948	6	67	54	20	6	1	..	..	154	118
1949	7	82	54	29	11	..	..	..	183	149
1950	6	98	71	23	19	1	1	..	219	188
1951	7	98	64	22	13	5	1	1	211	187
1952	13	144	68	40	20	5	..	1	291	228
1953	14	117	60	38	11	9	1	..	250	191
1954	8	92	59	27	12	8	..	..	206	176
	<hr/> 73	<hr/> 833	<hr/> 585	<hr/> 276	<hr/> 121	<hr/> 44	<hr/> 5	<hr/> 4	<hr/> 1941	<hr/> 1553

APPENDIX G

ARGUMENTS FOR AND AGAINST THE LEGAL SALE OF NARCOTICS

By G. H. STEVENSON, M.D.

Drug addiction has been an increasing problem in British Columbia in recent years and a cause of concern to the general public, the merchants, the police, the courts, the provincial government and the medical profession. In spite of very diligent efforts on the part of the police and the courts, the number of addicts in the province appears to be on the increase and there is obviously a large illegal traffic in narcotic drugs to supply their demand. It is estimated that there are 5,000 addicts in Canada, nearly 2,000 of whom are located in British Columbia. Convictions in British Columbia under the Opium and Narcotic Drug Act amounted to 265 in 1953, and were 66 per cent of all such convictions in the entire country. Ontario, with $3\frac{1}{2}$ times the population of British Columbia, had only 99 convictions in 1953 (and only 70 in 1952). The reasons for the unduly large proportion of addiction in British Columbia are complicated and need not be gone into fully in this paper. However, it should be noted that more than 70 per cent of British Columbia's addicts began their addiction in this province (almost all of them in Vancouver) and there now exists in Vancouver an increasing colony of addicts who have what appears to be a dependable black market supply of their drug addiction—heroin. Most of the men of this colony support themselves by illegal means—shop-lifting, theft, breaking and entering, and by selling narcotics periodically, whereas the women, who constitute one-quarter to one-third of the total number, support themselves largely by prostitution and by assisting the men in criminal activities. There are some addicts who hold regular employment for varying lengths of time and most addicts have had periodic employment. However, it is obvious that such a large group of relatively unemployed and delinquent people must cost the citizens a large annual sum of money in stolen goods, police and court prosecutions and maintenance in prison.

It might be mentioned at this point that some people believe there is a large body of non-delinquent addicts in the community, who are presumed to work steadily and to be otherwise well-adjusted persons. The writer has not been able to find heroin or morphine users in this category. There doubtless are a few such persons, chiefly in the medical and related professions, but anyone who has had professional relationships with such persons realizes their erratic undependability and the hazard they are to their patients when under narcotic influence. There are also non-delinquent persons addicted to the barbiturates and pethidine (demerol), who secure their supplies on medical prescription. These substances are highly addictive and physicians need to be aware of these dangerous features in prescribing them. As addictions, they can be more damaging to the unfortunate user of them, than the more common drugs of addiction—alcohol, morphine, heroin.

The failure of the police to prevent a steady flow of illicit narcotic drugs to the addicts and the failure of prison sentences to cure them (most addicts return to narcotics soon after leaving prison), coupled with the steadily increasing numbers of addicts in British Columbia, have led the public to seek some other solution to what has so far been an insoluble problem. The methods proposed by the Committee of Addiction of the Vancouver Community Chest and Council¹, in their report of July, 1952, supported in December, 1952, by

a brief to the Federal Government were mainly (1) amendments to the Opium and Narcotic Drug Act to make a distinction between traffickers and users, (2) the setting up of treatment and rehabilitation facilities for addicts who want to be cured, and (3) the establishment of "narcotic clinics" where registered addicts might legally receive narcotic drugs in "minimum required dosages".

At this point it might be stated that the Federal Government has increased the penalties for illegal trafficking in narcotic drugs². A request has also been made recently to the British Columbia Government by the Vancouver Community Chest for the authorization of payment to hospitals for withdrawal treatment of addicts and for the setting up of rehabilitation facilities. No action, however, has been taken by the Federal Government to permit the establishment of "narcotic clinics" where addicts might obtain drugs legally. What are the arguments for the establishment of such "clinics"?

The Chest's Committee Report states some of them:

"3. The Federal Government should be urged to modify the Opium and Narcotic Drug Act to permit the provinces to establish narcotic clinics where registered narcotic users could receive their minimum required dosages of drug.

"The establishment of this register of narcotic addicts would maintain a constant check-up on the number of addicts by any community. It would also protect the life of the addict and support him as a useful member of society. The assistance would hasten his rehabilitation, or at least reduce the amount of his addiction since many of the stresses of the addict's life would be reduced.

"This action would within a reasonable time eliminate the illegal drug trade. The decision to modify the Opium and Narcotic Drug Act in this way would be most violently opposed by those who profit from drug trafficking, and one should expect opposition and interference from such criminals. Nevertheless, no addict will willingly strive for \$20 to \$50 per day through criminal activities, if unadulterated drugs could be obtained for a few cents at a government-operated clinic. The operation of such clinics would not entail any reduction in the vigilance of law-enforcement agencies."

Addicts themselves enlarge on or add to these arguments as follows:

1. If drugs were legally available, the cost of drugs would be nominal and the addict could easily support a modest habit from his wages.

2. He would not be in constant conflict with the police nor would he be sent to gaol.

3. Absence of police arrests and gaol sentences would enable him to work steadily, advance in his work and maintain himself and his family in respectability.

4. Employers are reluctant to employ anyone with a record of gaol sentences, especially addicts, a situation which legal sale would obviate.

5. If he could buy his drugs legally, he would not have to pay the exorbitant prices demanded on the black market (the only market now available) and which, to pay, he has to secure money illegally, as the average habit of four or five capsules a day costs him at present at least \$15 a day and up to double that amount.

6. Lengthy gaol sentences interrupt work and family life and force the addict into a continuous life of crime.

7. The addict states that he is less of a danger with heroin in him than he or other people are with alcohol in their circulation. He contends that with heroin he only wants to be quiet and relaxed, whereas the alcohol user is apt to be aggressive, quarrelsome and dangerous.

8. If drugs were legal they would lose their glamour and adolescents would not be attracted to them as they are now. Some addicts claim, too, that having learned to like narcotics, they resent the legal prohibition and are the more determined to get them, in much the same way as in the days of alcohol prohibi-

tion, when many people thought it smart to outwit the police, patronize the bootleggers and generally show their defiance of the alcohol prohibition law.

These arguments sound attractive. Nearly every addict quotes them and believes in them. Many people believe that legal sale is the answer to them. Books and articles favouring legal sale have been published. The Chest's recommendations were supported by quite a number of groups, as well as certain newspapers, some newspapers, some members of parliament and of the provincial legislature. Support of the plan of legal sale rests on the apparent reasonableness of these arguments, the increasing number of addicts in British Columbia, the increase in crime which is attributed to addicts, and the failure of the police to prevent a large black market in Vancouver. A part of the support may be due to the belief that narcotics may not be as harmful as is commonly believed. There are those, too, who, holding such a belief, consider it only fair and right that a person who prefers morphine or heroin to alcohol has as much right to them legally as he has to alcohol legally.

It should, of course, be stated that this recommendation of the Chest's committee was not a *de novo* recommendation. Legal sale in various forms has been known and practised in various countries for many years, even centuries.

The best known example of extensive legal use of narcotics (in this case, opium) is China^{5 6 7 8 9 10}, where over 200 years opium smoking was openly indulged in. True, from time to time, Imperial edicts were issued forbidding the smoking of opium, but these were never seriously enforced, and by the treaty of 1858 between China and England, opium was legally imported into China for smoking, and continued to be legally used until well into the 20th century.

It might be mentioned at this point that the actual deleterious effects of narcotic drugs, on the individual user as well as on society generally, are also a matter of controversy. That the Chinese government should repeatedly try to stop opium smoking by its nationals implies that the government must have come to the conclusion that opium smoking was a bad thing. They believed it exerted a deteriorating influence on the users and that it conduced to national poverty and social degradation. Suffice it to say here that the habitual use of narcotics has unfavorable effects on both the individual and society, but that these effects have been largely over-stated by the opponents of the use of narcotics. Compared with a very commonly used narcotic, alcohol, the deleterious effects of the opium derivatives may be qualitatively and quantitatively less than those of alcohol. In their habit forming propensities, however, and in the narrow margin of safety between social use and addiction, the opium group is more hazardous than alcohol, but in all other respects, alcohol may be the more dangerous of the two.

This uncertainty concerning the actual deleterious effects of the opium group is responsible for the two extreme points of view held in Canada at the present time. The Opium and Narcotic Drug Act has been framed with the concept that narcotics are highly dangerous, that society has to be protected against them, and that persons who illegally secure narcotics, even minute amounts, must be punished severely, a minimum compulsory gaol sentence of six months being mandatory, with maximum sentences up to seven years for illegal possession of drugs, and up to 14 years for trafficking.

On the other hand, people who favor legal sale of narcotics have presumably come to the opinion that narcotics use *per se* is not too serious a matter, to either the individual or society, and that people who prefer heroin to alcohol should have the legal right to the drug of their preference, under properly and legally supervised conditions. In this connection, it might be noted that many careful observers in China were of the opinion that opium for the Oriental

was much the same as alcohol to the Occidental, that either could be abused, but that the majority of both races used their favorite drug in moderation without unfavorable consequences.

Reverting to previous experiences with legal sale of narcotics, it might be noted that the United States had no national law prohibiting narcotics until early in the present century (the Harrison Act was passed in 1914¹¹), and the use of drugs was completely legal (except for local ordinances) all during the 19th Century. Whatever drug addicts there were in the eastern United States during much of that time had become so largely through medical treatment of physical disorders, whereas on the west coast, drug addiction was largely confined to Chinese, who had been admitted to the country as a labor corps, and who had brought their opium smoking tendencies with them. They were permitted to import all the opium they wanted to use, with only a customs tax on it. Opium smoking spread in the 1860's and 1870's to the west coast under-world, and drug addiction as an acquired habit was quickly adopted by them¹². The reasons for the very severe legal penalties adopted in the early part of the present century are not clear, but fear and horror of drug addiction appear to have been partially responsible, as well as the belief that the use of narcotics not only branded the user as a worthless and vicious person, but also was responsible for causing much crime.

The remarkable difference of opinion in the U.S.A. as to the actual deleterious effects of narcotics was shown by the setting up of "narcotic clinics" in many cities of the United States about the year 1918¹³. Much the same reasoning was given then, as now, that legal sale of narcotics to registered users would reduce crime, would enable the user to get his favorite drug at reasonable cost and would allow him to work regularly, and illegal sale of drugs would be abolished. These "clinics" functioned until about 1923 and were finally all abolished, the results having been unsatisfactory. It is only fair to state that there were some people who felt the experiment had not been tried long enough and that the results were not invariably unfavourable. In those "clinics", too, the addict was given a supply of drugs to take with him, to be self-administered when desired, a situation which led to abuses, and might not be a part of the thinking for the "narcotic clinics" as envisaged by the Vancouver Chest's Committee.

The chief defects of these earlier narcotic "clinics" might be listed as follows:

1. "Clinics" brought criminals and drug addicts from areas where no "clinics" were available, increasing the number of idle, delinquent and prostitute classes in the cities where there were "clinics".

2. No attempt was made to cure addicts. The "clinics" were merely dispensaries for issuing drugs. Because of the peculiar need for increasing the dose of the opium products to get a pleasurable effect, addicts were constantly demanding larger and larger amounts. There could be no "basic minimum dosage" which would satisfy the addict.

3. The illegal drug traffic continued to flourish. Addicts who wanted more drug than the "clinic" would allow, patronized the illegal trafficker.

4. As the addict group were not generally employed, crime continued to supply addicts with additional money for their added drug supply.

5. Prostitution flourished openly in the areas where "clinics" were located as most women addicts, then as now, were prostitutes and supported themselves in this way.

6. Addicts would register their non-addicted wives and friends as addicts in order to get the supplies which would be issued to them.

7. Addicts would move from "clinic" to "clinic", or from town to town, where "clinics" were located, hoping to increase their drug allotments.

It will be noted that the word "clinic" is used in quotation marks in these comments. This word ought to have some medical or treatment connotation, but as used in the "clinic" experiment in the United States it had no such meaning. True, these so-called clinics were operated under medical supervision but no attempt was made to treat the addict for his addiction. They were, in fact, nothing more than legal outlets for the sale of narcotics to addicts. It is likewise difficult to see how the "clinics" advocated for Canada could be anything different. One might as well call a beer parlor or a liquor store by the name of "alcohol clinic".

Another nation which is commonly quoted as proof of the workability of legal sale is Great Britain. Addicts frequently ask, "Why can't we have the same system they have in England?" The implication is that addicts can get their drug requirements in England legally (and without cost through the National Health Scheme) and that they can be employed regularly and avoid the hazard of arrested imprisonment.

What is the English "system"?

In the first place it needs to be remembered that Britain has never had a drug addiction problem of comparable size with that of Canada or the United States, reporting to the U.N. Commission on Narcotics only about 300 recognized addicts in a population of 45 million. It has never had a large influx of opium-using Chinese, as have Canada and the United States. Britain has an underworld, but narcotics have never become common among its members, and are virtually unknown in the prison population of Britain, as contrasted with the prison population of Canada, where 15 per cent or more of prisoners in British Columbia are or have been drug addicts. British authorities have never allowed narcotics to get a foothold on the people, other than those who became medically addicted by physicians as a part of their treatment for physical diseases. For example, in 19th Century England, opium was freely administered for tuberculosis and not a few people became chronic drug users as a result. Also in the 19th Century, a few literary people became self-addicted, usually claiming physical reasons for starting, and De Quincey's "Confessions of an English Opium Eater"¹⁴ is a good study of a member of this group. The point to be emphasized is that there is no real parallel between the drug addiction problem as between Britain and Canada, and there need be no similarity in the methods of handling their respective problems.

But it is important to understand the English "system" for the additional reason that some advocates of legal sale of narcotics do not favor the "narcotic clinic" idea but favor legal sale through physicians. One of the most earnest advocates of legal sale in British Columbia invariably emphasizes and recommends what he calls the British "medical treatment" method. He would have addicts get their required supplies through physicians who would be authorized to supply prescriptions for them. That is, of course, a serious debasing of the concept of "medical treatment", as it is the duty of physicians to treat patients in the hope of ameliorating or curing the pathological condition. To ask physicians to be dispensers of narcotic drugs is to ask them to take on the function of the "beverage room" or liquor store. That this plan has earnest advocates is due not only to their belief in its efficacy and to their belief in the non-injurious effects of the usual opium group, but also because these persons realize that the "narcotic clinics" plan advocated by the Chest's Committee on Addiction would present tremendous difficulties of operation. Where would such "clinics" be located? Would every town be required to have one? Would they be open 24 hours a day? Who would pay for their upkeep? Would they be in every province? If a person lacked funds to pay for his drug would he be given it without charge? Would the addicts have to be given the drug in

the "clinic" itself, or would he be allowed to take drugs to his home for self-administration? Even if Parliament approved such a plan, it would probably be the responsibility of each province to implement it or to decline to implement it, and what would happen if British Columbia alone implemented it and set up "clinics" in the larger centres? Would drug addicts come to British Columbia from all other provinces not having such "clinics"? If an addict wanted cocaine, could he get it from the "clinics"? If an addict moved from Vancouver to a small town in the interior, how would he get his drugs in this new location? Would the proposed register of addicts be closed when all current addicts were registered, or would it be opened periodically to include new addicts who had become illegally addicted in the interval? Moreover, if legal sale were approval for Canada, would this mean that ex-addicts, having completed their sentences in gaols and penitentiaries, would be permitted to resume their addiction legally through "narcotic clinics" or by physicians' prescriptions? Why should ex-addicts be encouraged to resume their addiction?

The alternate proposal of making the medical profession the official dispensers of drugs would do away with all these problems just enumerated, because physicians are located in all parts of all the provinces. In other words, drug outlets would be already established in the physicians' offices, if physicians were authorized or required to supply narcotics to addicts. Is it conceivable that the medical profession would consent to become a legal outlet for narcotics to addicts, merely to perpetuate their addiction? The only proper relationship of the physician to the addict is that of helping the addict to overcome his addiction. Physicians are entitled to treat addicts, but treatment can rarely be expected to be successful by the ambulatory method or by office practice. Hospital facilities with security provisions, skilled nursing, constant medical supervision and treatment are all essential, followed by an adequate rehabilitation program.

To return to the English "system", it should be stated at once that England does not encourage, or even permit, the administration of narcotics to addicts for the purpose of addiction only. There must be sound medical reasons for a physician to administer narcotics to a patient, or to issue a prescription for them. If prescriptions are issued, they are treated the same as any other prescription and are filled by the druggist without direct charge to the patient under the provisions of the National Health Scheme.

Nevertheless, it is true that under certain circumstances drug addicts can receive regular supplies of narcotics on medical prescription. No register is kept (as is recommended by the Chest's Committee), but each physician treating an addict must report the addict by name to the Home Office, and the physician is obligated to do his best to cure the addict of his addiction. If narcotics are to be administered over a considerable time, the physician is expected to have a second physician consult with him on this matter. If he learns that the addict patient is getting additional narcotics from another physician as well, he is expected to discontinue treatment and report the circumstances to the Home Office. These regulations are related to the "Dangerous Drugs Act"¹⁵, under which act narcotics are controlled. Under this act a "Memorandum as to Duties of Doctors and Dentists"¹⁶ has been prepared which instructs such persons on their responsibilities in prescribing narcotics to addicts. The following quotations are from this "Memorandum":

p. 4. "The continued supply of drugs to a patient, either directly or by prescription, solely for the gratification of addiction, is not regarded as a 'medical need'."

p. 8—sec. 28. "A doctor who obtains, attempts to obtain, or who administers or supplies them (i.e. narcotics) otherwise than for the purposes of bona

fide medical treatments *commits an offence* against this act. The abuse of this authorization in order to obtain drugs for the gratification of addiction is an example."

p. 10—sec. 51. "Morphine or heroin may properly be administered to addicts in the following circumstances, namely:

- (a) Where patients are under treatment by the gradual withdrawal method with a view to a cure.
- (b) Where it has been demonstrated, *after a prolonged attempt at cure*, that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced.
- (c) Where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered becomes incapable of this when the drug is entirely discontinued.

p. 10—sec. 52. "Precautions in the Treatment of Addicts by the Gradual Withdrawal method. 'In these cases the primary object is the cure of the addiction if practicable. The best hope of cure . . . in a suitable institution or nursing home . . . (or) the practitioner . . . attempt to cure his condition by steady, judicious reduction of the dose.'

p. 10—sec. 54. "Precautions in Treatment of apparently incurable cases (these cases under (b) and (c) of sec. 51 above). 'In all such cases the main object must be to keep the supply of the drug within the limits of what is strictly necessary. The practitioner must therefore see the patient sufficiently often to maintain such observation of his condition as is necessary for justifying the treatment'."

It will be seen from the foregoing that the English method of dealing with drug addiction can by no means be equated with "legal sale" or "narcotic clinics". Moreover, it must be realized that the rarity of drug addicts in England is coupled with a traditional belief, not substantiated by actual experience, that some addicts cannot be cured because of their suffering while on withdrawal treatment and that some may need narcotics in order to work. With our vast experience on this continent, we realize that English concern with such possible hazards and difficulties is completely unwarranted. Withdrawal treatment can be performed in a few days in practically every case and without undue suffering on the part of the patient. Moreover, every addict can work better after he has discontinued the use of narcotics and has had a reasonable convalescence than he was able to do while he was addicted. When one sees the way addicts improve in weight and in their general health following discontinuance of narcotics, and how much better they are able to work, one realizes the lack of need for such over-cautious handling of addicts as is the custom in England.

Even if Parliament were willing to amend the Opium and Narcotic Drug Act to permit legal sale, it would have to forego its obligations in the United Nations pacts to which Canada is a signatory, and in which Canada and the other signatories are pledged to fight drug addiction. This has been well set out in a paper by Mr. R. S. S. Wilson¹⁷, published in the Vancouver newspapers in reply to the Chest's Committee's report. It has also been noted in a paper by Mr. G. W. Cunningham¹⁸, U.S. Deputy Commissioner of Narcotics. True, there is no reason why a nation might not adhere to its United Nations commitments and still try out new methods of managing its addiction problem, but the method proposed appears to be in contradiction to Canada's international commitments.

There is very grave doubt that permitting addicts to receive drugs legally would actually result in good employment results or any sizeable diminution

in crime. The "narcotic clinic" experiment in the United States gave no support to these theories. Moreover, detailed studies of the employment and delinquency records of British Columbia addicts indicate that these poor records are not the result of narcotic use, but largely preceded these use of narcotics. More than 70 per cent had unsatisfactory work records before they started on drugs and an even larger group had been delinquent before starting on drugs. Certainly the continued use of narcotics under present circumstances does tend to increase still further the addict's unsatisfactory social adjustments, but it should be made clear that basically their unemployment and crime records are not caused by drugs but preceded their drug use. There is no reason to think that by allowing addicts to be chronically under the influence of narcotics, they will improve their capacity for work or change their lifetime habits of delinquency.

It is also worth noting that 75 per cent of the group were heavy users of alcohol before starting narcotics, and had not infrequently been in trouble because of alcoholic excesses.

This data on the occupational history, delinquency records and alcohol use of drug addicts both before and after starting narcotics is very important because it indicates that drug addiction is not an unfortunate habit acquired innocently, but is part of a general personality disorder. There is no reason to think that simply curing the addict of his addiction, or on the other hand, supplying him with all the drugs he wants at minimum prices, will solve his problem. In both cases there is the underlying personality distortion and antisocial tendencies which have to be recognized and dealt with. Supplying the addict with free or low-cost narcotics cannot be expected to change him into a mature, socially well-adjusted citizen. Whatever chance there is of helping him will have a better likelihood of success if he is first freed from narcotic domination.

The next argument for legal sale is that it would eliminate smuggling and the illegal traffic generally. This surmise sounds as if it might be theoretically correct except for the fact that legal sale, under whatever form, never has defeated the illegal traffic. Legal sale in China and other Asiatic countries went parallel with illegal sale.

In China, as indicated time and again in books dealing with the opium problem there (4, 5, 6, 7, 8, 9, 10) the illicit traffic was always functioning successfully in spite of severe penalties at times, and even when drugs could be purchased through legal channels.

In Hong Kong, where opium was sold by the Government to addicts, only 800 applied for legal opium as compared with 68,000 addicts who obtained drugs from illicit sources. (Quoted from Narcotic Clinics in the United States.)

The same circumstances prevailed in the United States when opium and other narcotics were legally available.

In a one-year period in the 1920's when these clinics were in operation, the volume of illicit peddling of narcotics reached the point where 71·151 ounces of narcotic drugs were seized in the domestic illicit traffic—or more than 14 times as much as was seized in 1952. (Quoted from Narcotic Clinics in the United States.)

Theoretically, the addict would get his rationed supply from the "narcotic clinic", but it is one of the certain facts about heroin use that larger and larger doses are required, because of the peculiar mechanism of "tolerance". To get the desired effect the dose has to be steadily increased. Unless the "clinic" is to sell the addict as much narcotic as he requests, he must go to illegal sources for the amounts he wants. The legal outlet becomes a sure source for only his

minimum purchases. The illegal traffickers will still supply the excess he wants at prices which would still involve the addict in crime to secure money for its purchase.

Moreover, the addict would still have difficulty maintaining good employment because employers know that the average addict is, to say the least, an unstable personality. If an employer has to choose between a person taking drugs (legally or otherwise) and a non-user of equal ability, he would choose the non-user. True, the employer might never know that the addict was such but it is difficult to keep a matter of this sort a secret. The legally addicted addict would still be an addict, and would still consider himself discriminated against if he lost his position or was unable to secure remunerative employment, and, as at present, might readily revert to crime and heavier drug purchases from the illegal market.

The argument that the heroin user is less intoxicated and less of a menace than the person under the influence of alcohol is a sound one. It is vitiated, at least in part, by the fact that the user of alcohol seldom is under the influence of alcohol while at work, reserving his evening and week-ends for drinking. But the heroin user has to take several "fixes" a day, which means that he is chronically under narcotic influence, sleepy, indolent, careless and lacking in energy, or he is having distressing abstinence symptoms which again interfere with his work and require him to interrupt his work to re-intoxicate himself.

The argument that if drugs were legal they would lose their glamor and would not appeal to adolescents is very questionable. Legal sale of alcoholic beverages has not made them unattractive to our adolescents. There is no reason to think that the predisposed persons who become today's addicts, and who become so in adolescence or early adulthood, would not have become drug users if narcotics had been legally procurable. Supportive evidence for this assertion is that 75 per cent of this series of narcotic addicts had already become heavy users of alcohol (which is also, of course, a narcotic), even though alcohol was legally available. If morphine was available through legal sale there would undoubtedly be an increase in the number of people who would want to use it.

It should be admitted that there is nothing essentially evil or criminal in the taking of a chemical substance which tends to relieve stress and strain (19, 20). Tobacco has some such effect in times of tension or as a relief from ordinary stresses. Alcohol has still more of an effect in promoting relaxation. Both of these chemical substances can be used legally with no loss of social prestige if used within reasonable limits. The opium derivatives are also sedatives and relaxants and are preferred by some people over alcohol. To label such persons as criminals and to sentence them to prison merely for having in their possession minute amounts of these chemical substances can be regarded as very severe treatment of them. And there is no doubt that prison sentences often tend to make the prisoner resentful and hostile. They cause him to lose his employment and break up his home, and may be determining influences in leading an otherwise non-criminal person into a lifetime of crime and prison sentences. The drug addict has a real grievance, but it should not be assumed that legal sale of narcotics is the answer. And legal sale of the narcotic, alcohol, does not in itself justify the legal sale of another narcotic, morphine, even though the effects were no more than the effects of alcohol. While most people can and do use alcohol moderately, it should be realized that the world pays a tremendously high price in money spent, accidents induced in part by alcohol, physical disease caused by alcohol and homes broken by addition to this alcoholic drug. But because most of us demand the right to use it in moderation, we accept the price. Canada has approximately 5,000 narcotic addicts. It has more than 100,000 alcohol addicts, and a great many more who

are periodic hazards to themselves or to others through over-indulgence. Do we want a similar problem through narcotics to that caused by alcohol? While it needs to be appreciated that the 5,000 narcotic addicts are what they are largely through personality defects, inherited or acquired by unfortunate conditioning in childhood, nevertheless, merely because these 5,000 people (or most of them) demand legal sale of narcotics is not a sufficient reason for granting that request. They should be helped not only to be relieved of their drug addiction but their other anti-social propensities as well. With few exceptions they have been anti-social from an early age and have not accepted the responsibilities which the average citizen is required to accept and conform to.

It is obvious that there is no ready or easy answer to the addiction problem. As most addicts have had unfortunate home and parental influences during childhood, constant efforts should be made to improve the home life of our children.

The immediate needs are for still more vigorous efforts by the police to combat the illegal traffic in narcotics. This problem is extremely difficult for a variety of reasons but should not be insoluble if enough planning and effort goes into it. In wartime, solutions were found to more difficult problems. Another urgent need is for treatment facilities. Most addicts desire at times to be rid of their addiction, but the curious fact remains that with the largest addiction problem in Canada, British Columbia has steadfastly refused to provide treatment facilities. There is hope that this situation will be rectified and the medical profession is urged to support such plans. Most addicts are not without good intelligence and some attractive personality characteristics. If these assets can be salvaged, not only will the numbers of addicts be decreased but there will also be the likelihood of reducing the number of young people who might otherwise become addicted, as addiction usually spreads by contact between addicts and predisposed young people.

The attempt has been made in this paper to present as comprehensively as limited space permits, the arguments for and against the legal sale of narcotics, with certain historical and critical comments. Although these arguments have been presented as objectively as possible, for the information of the medical practitioners of the province, it will nevertheless be obvious that the writer has been brought to the conclusion that the proposal for legal sale of narcotics, if adopted, would not only fail to solve the addiction problems but would actually make them more serious than they are at present.

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APPENDIX H

"YOU CAN PREVENT DRUG ADDICTION—AND CURE VICTIMS OF HABIT"

G. H. STEVENSON, M.D.

The World Health Organization's Expert Committee on Drugs Liable to Produce Addiction defines narcotic drug addiction as follows:

"Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
2. A tendency to increase the dose;
3. A psychic (psychological) and sometimes a physical dependence on the effect of the drug".

Translated into non-technical language, the points of emphasis are:

1. That certain drugs are taken by certain people for their peculiarly pleasant effects (quite apart from medical values);
2. That these drugs, taken as intoxicants, are injurious to the user as well as to the general public;
3. That the user develops a tremendous craving for them;
4. That the user will go to any lengths to get his favorite drug, even to criminal acts;
5. That the user commonly has to take increasingly larger doses to get the desired effect;
6. That life becomes intolerable to the user without his favorite drug and he becomes physically ill if deprived of it.

The word narcotic is derived from a Greek word that means pain-relieving and sleep-inducing, but in English it includes all the drugs having characteristics that could lead to addiction, although not all of them are necessarily pain-relieving or sleep-inducing. But all of them have the quality of producing a seductively pleasant change in the way a person feels.

The best-known narcotic drug is opium, produced from a type of poppy grown largely in China, India, Iran and Turkey. From opium are derived morphine, codeine and heroin.

Heroin is the chief drug of addiction in Canada and the United States. Although heroin has not been available, even for the use of physicians, in the United States for 30 years, and has not been available to Canadian physicians since Jan. 1, 1955, it is smuggled into the United States from Europe, Mexico and the Orient, and is then transported into Canada by black market syndicates, and becomes illegally available to drug users in our larger Canadian cities.

It is a white powder and is usually put up in one-grain gelatin capsules, greatly reduced in strength by the addition of milk sugar or similar substances. The addict pays \$5 (more or less) for each capsule, containing only a small fraction of a grain of heroin, which, at ordinary retail prices, would be worth only a few cents. This gives some indication of the huge profits made by those in the smuggling and selling of narcotic drugs.

Other narcotic drugs are cocaine (used very little today by addicts), and the cannabis (Indian hemp) derivatives—hashish and marijuana. Hashish is used considerably in certain Oriental countries, whereas marijuana, in the form of cigarets known as reefers, has a large illegal sale in the United States, but is seldom used by Canadian addicts. Reefers are specially favored by dance-band musicians, who believe they can play hotter music after smoking marijuana.

Marijuana's effects are relatively mild, but its greatest danger lies in its use by thrill-seeking adolescents, because in certain U.S. cities adolescent smokers of marijuana not infrequently go on to the use of heroin.

These, then, are the three main groups of narcotic drugs:

1. Opium and its derivatives, morphine, codeine and heroin.
2. Cocaine (the coca plant is grown largely in the East Indies and in certain South American countries), and
3. Cannabis (Indian hemp) and its derivatives, hashish and marijuana.

It might be noted, as a botanical note, that all come from plants that have to be harvested carefully and then treated in various ways before being manufactured into the particular drugs included in the category of narcotic drugs.

There is a fourth group, the so-called synthetic drugs, which are manufactured from simpler chemical substances directly, and which have narcotic effects. The best-known of these, although there are dozens, are demerol and methadone.

These four groups of narcotic drugs come under international control, through the Commission on Narcotic Drugs of the United Nations. More than 40 years ago the first international conference was held (The Hague, 1912) in an effort to control by international agreement both the legal and the illegal traffic in narcotic drugs, and to reduce or eliminate the abuse of narcotic drugs through drug addiction.

The League of Nations and the United Nations sponsored later international conferences, which sought greater international co-operation in the elimination of opium-smoking and drug addiction generally, and the control of the growth of the opium poppy and its manufacture into drugs in quantities that would be enough for medical and scientific purposes only.

These international conferences have also set up machinery for regulating and controlling the amounts of narcotic drugs that could be imported and exported for legal medical purposes, as some of these drugs have great medicinal value. However, the cannabis group are now considered to be unnecessary in medical practice, and heroin also has been discontinued by many countries, as it is now known that other less dangerous drugs can replace it.

In addition to the four groups of narcotic drugs that come under international control there are other narcotic drugs that have only national regulation. One of these is alcohol.

Alcohol for some people is a drug of addiction. Although the great majority of people can and do use alcohol moderately and with little or no danger to themselves or others, it should not be forgotten that alcohol in its total effects, qualitatively and quantitatively, can be an addicting drug.

There are at least 20 times more alcohol addicts in Canada than heroin addicts. Alcohol also does much more physical harm when used in excess than heroin does to its user. As to social damage, alcohol accounts for many more broken homes, unhappy marriages, deprived children, total expense, and traffic accidents, than does heroin.

But because most people demand the right to use alcohol legally and because governments obtain considerable revenue from taxes on alcohol, it would seem that we are prepared to accept this terrific personal and social damage as a fair price for the privilege of general use of alcoholic beverages.

The barbiturates are another narcotic group that does not come under international control. This period in world history may be known not only as the atomic age but as the barbiturate age. Barbiturates are taken as sedatives and as sleeping medicines by a very large number of people. While most barbiturate users take these chemical substances moderately and under medical advice, it is not difficult to become addicted to them.

Their toxic effects are much like those of alcohol, and some authorities consider barbiturate addiction as having greater potential hazards than addiction to either alcohol or heroin. Not a few people, too, die from overdose of sleeping pills (either accidentally or with suicidal intent), as heroin users sometimes die from overdosage, and somewhat similarly, some alcoholics drink themselves to death, both figuratively and literally.

Amphetamine (commonly known by its trade name of benzedrine), while not ordinarily thought of as a drug of addiction, is used to excess by some people for prolonged stimulation, and at times for a narcotic effect, and sometimes to counter the effects of barbiturate excesses. The use of benzedrine is said to be common at present among Japanese adolescents.

Close to the drugs of addiction, but more properly called a habit-forming drug, is nicotine, the active principle of tobacco. Certainly, people use tobacco for its pleasantly relaxing effect, but tobacco is not without its physical hazards to the user.

A number of physical disorders, such as cancer of the lung, heart disease, ulcers of the stomach and bronchitis, are, in some cases, apparently related to heavy smoking of cigarets. Smoking produces relatively little social damage, however; its chief social hazard is fire, which not infrequently is the result of smoldering cigaret butts.

Perhaps if we ask ourselves why we use tobacco and take alcoholic beverages, we can, at least partially, understand why some people take narcotic drugs. Basically, we use tobacco and alcohol to increase our comfort or to relieve our discomfort.

Discomfort may originate in physical disturbances, in distressing memories, in anxious fears and in our social relationships. All of us are uncomfortable at times, some of us are uncomfortable all the time. We may try to remove the causes of our discomfort, if they are removable, by correcting the situation; if physical, by proper medical attention and hygienic living, or, if emotional, by solving the problem or destroying the disturbing irritant.

Often we cannot completely solve the problem or remove the offending social irritant. We may have to bear our difficulties with what courage, philosophy, religion, and endurance we may possess.

On the other hand, we may try to deaden the pain, if physical, by an appropriate medicine, prescribed by a physician, or, if the distress is emotional, by possibly using the same drugs in intoxicating doses.

Drug addiction, therefore, tends to occur chiefly in people who desire to increase their sense of comfort and well-being, but who lack the capacity or the training for ordinary adult social responsibility and who lack perseverance and opportunity for attaining the ordinary social values. They find in a narcotic drug a satisfaction they fail to get from life, and then find themselves controlled by the demands of a drug that refuses to be sent away.

This is what the addict calls being wired or hooked or what is also designated as "the monkey on his back". If he tries to break away from the drug he has withdrawal symptoms, which usually consist of nausea and vomiting, several pains and aches in the abdomen and legs, great restlessness, sleeplessness, and an over-whelming desire for the drug.

It should be noted that a person only becomes addicted if he is in close contact with other users of narcotic drugs (or in the case of doctors and nurses, with the drug itself). Hence drug addiction originates very largely in

large cities, where there is already established a colony of drug addicts and a black market where drugs can be readily purchased.

Thus, most drug addicts are recruited from the underworld, and most of them have been in trouble with the law before they start on drugs, as a result of all the factors that contribute to juvenile and adult delinquency.

A much smaller group of addicts comes from the professional classes: physicians, nurses, dentists, pharmacists—people who are closely associated with drugs, who know their medicinal values but take chances with them, to alleviate their own personal frustrations and distresses. There is also a small group of persons who start to take narcotic drugs for medical reasons, perhaps even under medical direction, and who become so attached to the drug that even when the medical need no longer exists they continue the drug for its intoxicating effects.

The general public has a horror of drug addiction and of drug addicts, largely the result of lurid tales of crazed "dope fiends" in the sensational press and in journals that depend for their success on sensational stories.

Drug addicts are usually depicted as engaging in crimes of violence, of being degenerates, and of being completely outside the pale. They are, we are led to believe, to be avoided as the plague. They are punished by long terms of imprisonment if caught with the tiniest fraction of a grain of heroin in their possession.

Actually most heroin addicts are pathetic figures. They have usually been handicapped by poor home life in childhood and, although usually of normal intelligence, they have personality weaknesses that make it difficult for them to adjust to society's demands. They use drugs to relieve their basic unhappiness, and when they become addicted, they continue because they find themselves unable to get along without drugs, even though they no longer get much of the satisfaction they once got from drugs.

Heroin does them less harm physically than that caused by either alcohol or tobacco (unless they die from an overdose), but the use of drugs does decrease their capacity for remunerative work, and employers will seldom hire an applicant, or keep an employee, who uses drugs or has a history of drug use.

They therefore commonly increase their stealing, to keep themselves and support their habit, which, at black market prices, will cost \$10 to \$50 a day. Women users, of whom there are approximately half as many as men, commonly resort to prostitution to buy drugs.

It should also be noted that heroin acts as a sedative to sexual impulses, so that male heroin addicts are very rarely connected with sex crimes against women.

Far from being stimulated to crimes of violence, the average addict is concerned only with getting money (usually by shoplifting, shopbreaking or bad cheques) to buy an adequate supply of drugs and with avoiding people, until it is necessary for him to again seek money to buy more drugs. There are always exceptions, however, and some addicts do have violent propensities and can be dangerous in their criminal activities.

The World Health Organization has defined health as the achievement of the best possible physical, mental and social well-being of the individual and not merely the absence of disease or infirmity.

By this definition, drug addiction is a sickness and the drug addict is a sick person. The drug makes him physically intoxicated and debilitated, he is mentally sick in that he has no peace of mind, and he is socially sick inasmuch as he is poorly adjusted in life, is constantly victimizing society and constantly being hurt by society.

He is not cured by sending him to prison. Prison may more likely confirm him in underworld life and decrease his capacity and opportunity for social readjustment.

Treatment for the drug addict involves three phases. The first is that he must be willing to be cured of his addiction. He must, like the alcoholic, realize that there is no satisfactory future for him by continuing in addiction, that addiction is a dead-end street, and that reality painful as it may be, is likely to be better than a lifetime of drugs, unemployment, crime, jail, slums and social antipathy.

Treatment should be voluntary, not compulsory. It should also be stated that many addicts would gladly be cured of their addiction if they could see the possibility of a real cure and of a better life than that they lead.

Secondly, he must have withdrawal treatment in a secure environment, preferably in the psychiatric section of a general hospital, where he can have good medical and nursing care, where he can be protected from the well-intentioned but misguided friends who would seek to bring drugs to him, and where, having entered voluntarily, he must stay until the drugs have withdrawn from his body and normal physiological functioning has again taken control.

He can be helped during this stage by certain sedative drugs, warm baths, proper diet and psychotherapeutic assistance. This phase of treatment should be of not less than two weeks' duration.

The third stage of treatment is rehabilitation. This involves physical and mental convalescence in a drug-free environment.

He will be restless and sleepless for several weeks, perhaps longer, and this convalescent period should be devoted to the building up of his depleted physical condition and to helping him gain additional insights into the reasons for his former drug use.

There should be a program of recreational and occupational therapy to get his body and mind functioning more normally again. A satisfying job should be located as soon as circumstances permit, a new set of recreations and hobbies should be substituted for his former habits. A new set of friends should be sought with careful avoidance of old friends and old haunts, as addict friends will try to lure him back. As with the recovered alcoholic, for whom one drink can be his undoing, so one heroin "fix" can destroy all the effort that has gone into the addict's treatment.

There is no insuperable barrier against successful treatment of the drug addict, in spite of the prevailing pessimism and the well-known tendency to relapse.

The absence of treatment and rehabilitation features in most communities, coupled with long prison sentences for possession of even minute quantities of heroin, have all militated against a humanitarian approach to the treatment of the addict.

The addict, embittered and hostile, has done little to encourage optimism or to co-operate with those who would help him. But if the addict can get or be given a net set of values, and if proper treatment and rehabilitation facilities can be made available to him, his hopes of a drug-free future may be realized.

A final word about the prevention of drug addiction. Everything that builds up a good home-life for children is helpful, including parents who are trained to train their children. The rules of mental hygiene should be more assiduously taught and practiced. There should be social and economic opportunities for all people.

All these are fundamental. A proper system of values for the adolescent is also of paramount importance and the avoidance of companions and circumstances that militate against a good value system.

Rarely, if ever, has anyone become a drug addict except by contact with drugs or drug addicts. It is therefore greatly important that the police concentrate their efforts on the prevention of smuggling and trafficking in narcotic drugs by eliminating the people who bring it into the country and arrange for its sale in our larger cities. The task will be difficult because the profits are enormous, but, to the extent that drugs are of decreased availability to that extent will young people cease to be made into addicts, and former addicts be made to relapse.

The problems of prevention and treatment of drug addiction are difficult but not insurmountable, and require concerted efforts on the part of all concerned—the medical profession—the police, a co-operative public and, last but not least, the addict himself.

By Dr. G. H. STEVENSON.

APPENDIX J

BRITISH COLUMBIA PENITENTIARY

APRIL 3rd, 1955

Statistics of Drug Addicts in the B.C. Penitentiary

1. There are 5 Criminal Sexual Psychopaths in the B.C. Penitentiary.
None of them are Drug Addicts.

2. *Population of the Penitentiary*

The total population of the prison as of this date in 663 inmates,
composed of

161 drug addicts.

502 non-drug addicts.

663

In percentages therefore, 24.3% of the population are drug addicts

3. *Average Age* of drug addicts is 34 years

The youngest of them is 18 years old

The oldest of them is 67.

4. *Nationality* 157 drug addicts are of Canadian Nationality 4 drug addicts
are of Foreign Nationalities.

5. *Conjugal Status*

80 addicts are single

48 A are married

18 A are divorced

11 A are married-separated

4 A are widowers

161

6. *Educational Standing of 161 Drug Addicts*

No schooling	2	inmates
Grade 2	1	"
Grade 3	1	"
Grade 4	2	"
Grade 5	5	"
Grade 6	8	"
Grade 7	13	"
Grade 8	55	"
Grade 9	32	"
Grade 10	22	"
Grade 11	11	"
Grade 12	5	"
Grade 13	4	"
University	—	"

161

7. List of Offences for Which Drug Addicts are serving their present sentences.

Possess drugs	88 inmates
Habitual criminal	7 "
Robbery with violence	5 "
Distribute or sell drugs	32 "
B. & entering	11 "
Robbery	1 "
Obtain goods by false pretences	1 "
Possess explosives	2 "
Steal auto	1 "
Theft	3 "
Possess drugs for trafficking	6 "
Receive stolen goods	1 "
Uttering & false pretences	3 "

161

Drug offences	133
Non drug offences	28

161

82% are serving time on drug offences.

8. Racial Origins

Drug Addicts of Canadian Racial Origins (British and French)

English and Welsh origins	40
Irish origin	27
Scottish origin	31
French origin	13

111

The above 111 inmates may be subdivided as follows:

101 are Canadian having been born in Canada.

10 are Canadian by virtue of having been born in the British Isles (England and Scotland) and entered Canada at least 5 years prior to the year 1947, for the purpose of permanent residence in Canada.

111 all Canadian citizens.

8. (a) Drug Addicts of Foreign Racial Origins

Austrian origin	1
Chinese origin	3
Finnish origin	1
German origin	10
Greek original	2
Italian original	4
Jewish (Herbrew)	4
Yugo-Slavian	1
Norwegian origin	2

Polish origin	3	
Roumanian origin	2	
Russian origin	7	
Ukrainian origin	8	
United States (Negro)	2	
		<hr/>
		50
		161
		<hr/>

Note: Of these 50 addicts who are of Foreign Racial origin 46 are Canadian Citizens, by virtue of having been born in Canada, and
4 are Foreigners, having been born outside Canada

50

In percentages: 31% of addicts are of foreign Racial origins; 64% of addicts are of Canadian origins (British and French.)

9. Table showing how many previous penitentiary sentences the 161 addicts have served

No previous penitentiary sentences	56	inmates
One previous penitentiary sentence	36	"
Two previous penitentiary sentences	25	"
Three previous penitentiary sentences	18	"
Four previous penitentiary sentences	15	"
Five previous penitentiary sentences	7	"
Six previous penitentiary sentences	3	"
Seven previous penitentiary sentences	1	"
		<hr/>
		161 inmates

In percentages: 65.2% have had previous penitentiary sentences; 34.8% have not had any previous penitentiary sentences.

10. Table showing the number of sentences on Drug Charges, and the number of sentences on Non-Drug Charges, imposed on these 161 drug addicts during their lives, including the sentences they are presently serving.

	Number of drug sentences	Number of non-drug sentences	Total sentences
161 addicts	377	980	1357

These 161 inmates therefore *average*

2.34 sentences for drugs charges each inmate.

6.1 sentences for non-drug charges each inmate.

8.4 sentences on all charges per inmate.

11. *Previous Records of Drug Addict Population.*

6 are first offenders (no previous convictions of any kind)

155 have served previous sentences either in the Penitentiary, goals, or reformatories, or combinations of these)

161

11 (a) The 6 first offenders are classified as follows:

The youngest is 22 years of age and the oldest is 34 years of age.

3 of them are serving sentences for possession of drugs; 2 for distributing drugs; 1 for giving away drugs.

Those guilty of distributing or giving away drugs received sentences each of five years and fined \$500.00 or in default of payment, six months additional. They were also sentenced to corporal punishment, two of them to five strokes of the paddle and one of them to ten strokes of the paddle (in two inflictions of five strokes each).

Those guilty of possession, received in one case seven years, and in the other cases two years and fined \$200.00, or in default of payment, 2 months additional.

12. Ratio of Prison Offences, in the case of drug addicts and non-drug addicts.

(a) Of the total of 161 addicts, 37 have been charged with prison offences.

This is 23% of the total drug addict population.

(b) Of the remaining 505 inmates (non-addicts) 127 have been charged with prison offences.

This is 25.3% of the non-addict population.

Conclusion. It would therefore seem that the drug addicts are less troublesome in the prison than the non-drug addict population.

13. Trade Training and Rehabilitation

Most of the addicts are anxious to learn a trade in the Penitentiary. The following are the totals learning trades in the categories shown:

Blacksmith shop	10
Carpenter shop	4
Canvas working	3
Engineer's department	7
Garage	1
Kitchen, including cooking and baking	13
Laundry	18
Machine shop	4
Mason's department	9
Paint shop	3
Shoe shop	5
Tailor shop	22
Tinsmith	2
Vocational carpenters	2
Vocational drafting	1
Construction	3
Farm and gardening	10
Total	117

In percentages—70 per cent of the addicts are learning trades.

14. I trust that this report will give you a better idea of how drug addicts live and behave in the penitentiary, and how they are treated there. I would like to add that many drug addicts are good athletes, participating in games such as boxing, football (soccer), softball, and also weight lifting.

I am of the opinion, taking into consideration the statistical tables of these addicts and their sentences, that serving time in the penitentiary, whether for a short period or for a long one, does not prevent an inmate from returning to drug addiction upon his release.

APPENDIX K

SUMMARY BY COMMITTEE COUNSEL OF TESTIMONY GIVEN IN
CLOSED SESSION DEVOTED TO RECEIVING EVIDENCE OF
ADDICTS AND RELATIVES AND/OR FRIENDS OF ADDICTS

WITNESS No. 1.

Sister of Addict Trafficker.

Addict is now 27 years of age. Parents were separated when addict was 3 years of age. Family consisted of 2 children—1 boy and 1 girl. Addict was raised in foster home. Returned to father when 14. Difficulties began at that time. Sister is not addicted. History of early juvenile delinquency—long criminal record—association with bad companions. Addict left home when 15. Acquired drug habit at 16.

Prior to completion of a 3 year prison term, witness had provided a home, money for clothing and other essentials for use of addict on release from prison. Addict was liable to pay a fine in addition to the sentence which was expiring. The sister had money for that purpose. Sister suspects that someone in drug syndicate paid fine for addict and he was released one month earlier than contemplated by her. She complains that prison authorities should have notified her before releasing him.

WITNESS No 2.

Father of an Addict.

Addict 43 years of age. Had no juvenile delinquency record. Became addicted when 15. Has been using drugs for 25 years. Has long criminal record and served terms at Oakalla Prison and B.C. penitentiary. Addict had good education—was good worker. Addict's wife worked to support only child who is now 21 years. Addict had treatment to break habit several times. Father became widower when boy 14—devoted much time to business. Addict acquired habit when working on freight boats. Witness complains that National Employment Office mark their cards to identify person as addict, making it difficult to obtain and keep work. Addict was working at out of town contract job and not using drugs when recognized by former guard at Oakalla, following which he was discharged.

Addict's wife worked at job handling much cash. Addict suggested pre-arranged holdup. She became nervous and had to resign her position.

WITNESS No 3.

Father of Female Addict.

Parents divorced when child 3 weeks old. Father kept her until 8 years of age, when he remarried. Successful businessman of adequate means. Girl acquired habit at 16. Father worked most nights. Stepmother suffered from mental illness. Daughter attended good schools. Acquired habit by association with known addict.

Witness willing to pay for hospitalization and treatment but no facilities available. Daughter convicted of shoplifting and prostitution. Father suggested attractive opportunities for new life elsewhere. Addict insisted on staying near source of supply of drugs. Addict's father believes that if treatment facilities had been available, and daughter removed from Vancouver, she would be well today.

Knows that daughter created 2 new addicts, one age 16. Witness opposes narcotic clinics. Complains that there are no facilities for treatment even for those willing to pay for it. Witness recommends an addict be given 2 or 3 chances and if he or she does not respond to treatment, that he or she be permanently segregated.

WITNESS No. 4.

Addict Trafficker.

Criminal record commencing 1931, consisting of shop-breaking, breaking and entering and theft. Possessing firearms, shop lifting, possessing stolen property, etc.

Has been in prisons in British Columbia and elsewhere. Had record of delinquency before becoming addict. Addicted at 16. Seems to be confirmed addict. Comes from good home—acquired habit out of curiosity. Stole drugs from relative's drug store to begin with. Has been without drugs for four years. Cannot tell how long he will remain away from drugs.

Would remove penalties for possession of drugs—would register all addicts except medical and professional addicts. Would legalize sale of drugs to addicts. Has had some experience with "Narcotics Anonymous". Advocates narcotic clinics.

WITNESS No. 5.

Addict Past Middle Age.

Long record of crime and drug offences, not detailed. Supported habit by fraud, cashing cheques, etc. Advocates narcotic clinics for supply of maintenance doses. Suggests dosage to continue while addict working at useful occupation. Has used drugs for forty years, obtained from doctors by representing himself to be ill.

WITNESS No. 6.

Former Addict Now Gainfully Employed.

Addict had delinquency record before addiction. Used morphine then changed to heroin. Described himself as "joy popper". He had several prison terms. Has been without drugs for four and a half years. Is convinced he will never use drugs again. Is training for entry to Communion of a church. Working steadily and completely rehabilitated. Has no craving for drugs any more. Last conviction not related to drugs but due to drinking. Finds life more meaningful without drugs. Has removed himself from drug atmosphere. States that he was never firmly addicted.

WITNESS No. 7.

Former Addict Now Well Established in Business.

Was a delinquent before acquiring habit, now married and completely rehabilitated. Member of "Alcoholics Anonymous". Home surroundings had

been unhappy. Acquired habit through association with addicts, thieves, etc. Change in life due to contact with religious group. Concerned about lack of after-care on release from prison. Suggests jail personnel had no experience in handling addicts.

Addict never deeply addicted, although has had severe withdrawal pains. Maintained habit by hotel prowling. Returned to drugs shortly after each release from jail. Found that peddlers were not looking for new customers. Has no desire to return to drugs but recommends establishment of narcotic clinics.

WITNESS No. 8.

Friend of Addicts.

Has worked with addicts as friend. Recommends establishing of hospitals for treatment of addicts,—one in British Columbia and one near Toronto. Recommends small institution for withdrawal treatment and rehabilitation. Recommends psychiatric treatment, vocational guidance and work training. Recommends close liaison between rehabilitation hospitals or centres and personnel managers in British Columbia. Would legalize the sale of drugs. States cause of addiction to be associated with other addicts. Recommends that Doctors be permitted to administer drugs. Knows fifty to seventy-five addicts now working and obtaining maintenance dosages. They support their drug habit by work though they obtain drugs through regular criminal channels.

WITNESS No. 9.

Former Addict.

Comes from broken home. No history of juvenile delinquency before acquiring habit. Habit acquired through association. Started as joy-popper. Used morphine and heroin and his regular habit was six capsules a day when he discontinued. Has also been peddler.

Has not been using drugs since 1938.

Since abstaining from drugs, has been in trouble with authorities—two offences—not related to addiction. States he knew confirmed addict who discontinued chiefly because he was afraid of conviction as an habitual criminal. Witness had been in army for several years. Believes that army life contributed to his abstaining from drugs. Although he had been exposed to drugs in line of duty as medical personnel, has not relapsed.

APPENDIX I

COMPARATIVE TABLE OF MISCELLANEOUS CRIME, 1944-1953, VANCOUVER

Classification	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953
Breaking and entering.....	2,588	2,355	2,466	2,186	2,301	2,406	2,268	2,409	2,224	2,194
Robbery with violence.....	221	247	247	216	240	209	232	191	177	186
Theft—Total.....	7,646	6,952	7,897	8,181	8,051	8,936	8,757	8,648	9,056	8,237
Auto thefts.....	1,362	1,520	1,728	1,565	1,701	1,782	2,067	1,938	1,441	1,622
Auto recoveries.....	1,357	1,514	1,727	1,561	1,693	1,778	2,054	1,917	1,420	1,615
Bicycle thefts.....	713	726	811	751	698	766	907	947	1,250	990
Bicycle recoveries.....	791	794	942	898	832	889	711	786	1,068	864
Murder.....	7	5	6	6	7	5	2	2	3	3
Stolen property.....	\$437,270	\$411,018	\$402,520	\$447,057	\$416,532	\$565,434	\$631,032	\$559,000	\$469,275	\$503,605
Recovered property.....	\$142,371	\$140,838	\$188,982	\$152,080	\$144,987	\$173,237	\$165,126	\$109,042	\$104,167	\$183,788
Population.....	311,799	323,850	339,350	354,150	376,000	386,000	397,140	385,500	390,325	393,500
Authorized strength.....	407	476	493	570	635	662	679	695	697	698

APPENDIX M

SUMMARY BY COMMITTEE COUNSEL OF EVIDENCE HEARD AT
OAKALLA PRISON FARM, BURNABY, B.C.

The session of the Committee held in the Chapel at Oakalla Prison was attended by approximately 150 addicts.

At the outset Warden Christie addressed the addicts and told them they were free to make such comment or criticism as they wished as long as it was done in a gentlemanly fashion. The addicts were at liberty to express themselves freely on the subject of narcotic drugs.

The Chairman also addressed the gathering stating that anything which the addicts would care to say would be considered by the committee who were anxious to hear them.

Twelve addicts of varying ages, ranging from young adults to middle age made representations. Without exception they all advocated the legalized provision of drugs. To these suggestions there was no dissenting voice from the other addicts who did not participate in the presentations. Some were quite bitter about the fact that, in their opinion, the professional and/or medical addict could obtain drugs with impunity. Some expressed the opinion that the only difference between the professional and medical addicts and the group at Oakalla was that the former two groups had sufficient money with which to support their habits.

Two female addicts also appeared, in camera, before the committee in another section of the building. There was nothing particularly significant in their backgrounds. They made no suggestions about the legal provision of drugs and did not know whether they would abstain from the use of drugs upon their release from prison. They both said it was difficult for them to make a prediction. Both said the decision to abstain permanently must come from within the addict. There were very many complicating factors to be considered. Both witnesses gave the impression that any major crisis in their lives might cause a relapse.

APPENDIX N

Excerpt from book written by Superintendent R. S. S. Wilson,
Royal Canadian Mounted Police

Published at R.C.M.P. Headquarters in Ottawa, 1951

CURE AND CONTROL OF THE ADDICT AS THE FINAL
SOLUTION TO THE NARCOTIC PROBLEM

If we accept the proposition that the narcotic problem is capable of solution, and no right thinking man would wish otherwise, how can we reconcile this with the generally recognized fact that the last thirty odd years of effort have produced no reduction in addiction or trafficking? In the international sphere every effort has been made to limit the production of opium to the medical and scientific needs of the world. Rigid controls, both national and international, have been placed on the export, import, manufacture and distribution of narcotics for the legitimate trade. An all-out attempt has been made by many countries, including our own, to prevent the illicit importation and distribution of narcotics. The problem of addiction has been studied by the medical profession and efforts have been made to effect cures and re-establish the addict as a useful member of society. But despite all this we are still confronted with addiction and trafficking on as large a scale as ever.

What is the answer? All authorities will agree that drug addiction and drug trafficking go hand in hand. Without one we cannot have the other. Some say that without addiction there can be no traffic; others take the viewpoint that drying up the illicit traffic will stop addiction. The medical man tries to cure addiction, the policeman and customs officer tries to stop the illicit traffic and the internationalist tries to control and limit narcotic production. The writer is of the opinion that only in a combination of all three lies the permanent answer to the drug problem.

If drug addiction is to cease throughout the world the production of narcotics must obviously be limited to the medical requirements of the world. But due to international conditions and the various other uncertainties involved, there is no immediate prospect whatever of this being accomplished. Moreover, there is an entirely new factor which must in future also be taken into consideration. All the years of international effort to limit the production of narcotic drugs to the medical and scientific requirements of the world may have been rendered completely useless by the advent of the synthetic drugs. The fact that a single unscrupulous chemist in this country has it in his power to produce sufficient synthetics to supply the requirements of the entire domestic illicit traffic, leads to a realisation that attempts to control the production of opium at its source and to prevent the illegal entry of narcotics into the country, are not in themselves enough.

As long as there are addicts seeking a source of supply, just so long will the terrific profits tempt the avarice of the potential supplier. If the supply of opium and its derivatives could be completely shut off from abroad, even if harmless non-habit-forming substitutes entirely took their place and thereby wiped out the legitimate drug trade as a source of narcotic supply, one thing is still certain and that is there would always be evil persons willing to step in and supply the addicts' wants with clandestinely manufactured synthetic drugs.

Leaving smuggling, international control and the potential dangers of the synthetics entirely out of the picture, what can we do now *within* our own borders to stamp out the evils of drug addiction? Our control over the legal

domestic trade is excellent and existing police measures to combat the internal illicit traffic, while always subject to improvement, can on the whole be classed as adequate. What then remains? *Cure and control of the addict!*

This is no easy thing—in fact, it constitutes a medico-legal problem of great complexity. Nevertheless, it is the definite and considered belief of the writer that drug addiction as we know it today, with all its attendant crime and evil, can be wiped out in Canada within a very few years if we are but willing to face the facts and attack the problem from a realistic point of view. It would probably be as well to emphasize at this point that the views expressed herein are the writer's own *personal opinions* acquired after lengthy experience with the police side of the narcotic problem. They should not, therefore, be interpreted as necessarily reflecting the official view of the Royal Canadian Mounted Police or of any other government body.

After years of contact with the criminals who make up the vast majority of our addict population, one fact stands up starkly—the constant ceaseless reversions. The addict, be he addicted peddler or plain addict (and who can differentiate between the two as every addict will peddle given the opportunity), is arrested and imprisoned. Whilst incarcerated he is physically cured of his habit. After six months or more he is released; he returns to his former haunts and associates and within a month or two is again addicted and the police, perforce, must start the whole useless round over again. Arrest, conviction, cure, release; arrest, conviction, cure, release—so it goes, “in and out, in and out” ad infinitum. One is reminded of a squirrel in a cage, or as William T. McCarthy, U.S. Attorney for Massachusetts, puts it in his article “A Prosecutor's Viewpoint on Narcotic Addiction” (October-December 1943 issue of Federal Probation Quarterly):

We are simply “shadow-boxing” with the narcotic problem if the drug peddlers are to be turned back every six months or so to resume activity, contaminate others, and to act as mechanical rabbits for the minions of the law to pursue.

With all the enthusiasm of youth and zeal of a crusader, does the young Mounted Policeman engaged on narcotic work attack his side of the problem, which is enforcement. Hours mean nothing to him, gladly he gives up his evenings, his weekends; though he knows that the long hours, lack of sleep and constant exposure to unhealthy and unpleasant surroundings will adversely affect his health, he drives himself on. This is not mere work to him; it is the pursuit of an ideal. For him the curtains have been drawn back and he has seen drug addiction as few others ever see it, has seen it in all its horrible reality, not in a hospital or prison, but amidst the sickening squalor, the stench and corruption of the pitiful surroundings the addict calls ‘home’.

As times goes by he begins to wonder if all is well, but like the ant he plugs away at his endless task, hoping against hope that the days and nights of work leading to the arrest of a peddler have been worthwhile and that some good will follow; somehow he hopes a blow, however small, has been struck at the traffic.

But in the end, perforce, he must pause and take stock of the situation. The addicts he knew years ago have either died of addiction or committed suicide, some are temporarily in prison, others temporarily on the ‘outside’ and still using narcotics, while the remainder have degenerated, if use of the word is permissible, to mere dregs of humanity on the skid-road, no longer physically or mentally capable of securing sufficient money to purchase narcotics, and seeking refuge in stupefying themselves with barbiturates, benzedrine and canned heat. At the same time he sees on every hand the new recruits to the vice, some mere boys and girls, who have started down the dreary, meaningless

road of drug addiction. At this stage there is driven home a full realization of the cost, and waste effort, the uselessness and utter futility of our present attempts to stop the drug traffic.

We can stop the drug traffic in Canada if we will do three things:

- (1) maintain international and domestic control over the legal traffic,
- (2) continue to wage war on narcotic smugglers and internal traffickers, and
- (3) *cure and permanently control the drug addict.*

Without pausing to ask if the latter could be made legally possible, or is morally justifiable, let us assume for sake of argument that on a certain date every addict in Canada were to be forcibly removed from the streets and jails and placed in a special institution; excluding, of course, the very small number of legitimate medical cases undergoing treatment for some terminal condition, such as cancer. What would happen to the drug traffic? With no one to sell to, the smuggler and peddler would be forced out of business and his supply of narcotics reduced to so much worthless powder. Moreover, there would, to all intents and purposes, be no peddlers left, as we know that nearly all drug peddlers are themselves addicts and these would, therefore, also be in the institution. The drug habit is spread through association. Hence the criminals and psychopaths who in the ordinary course of events are destined to fall prey to narcotic addiction, would have no one to initiate them into the vice. These would continue their way without recourse to narcotics just as they did seventy-five years ago when drug addiction was unknown on this continent.

If such a thing did happen and if the narcotic laws continued to be rigorously enforced, is it too much to assume that addiction to narcotics would cease to exist as a major problem in this country? It is the opinion of the writer that such would be the case. Furthermore, it is his sincere belief that in this way, and in this way only, lies the eventual solution of the problem of drug addiction in Canada.

It is the writer's contention that narcotic addiction must be regarded and treated as a disease in exactly the same manner as we now regard and treat the various forms of mental disease. The only difference is that there are no "mild forms" of drug addiction which do not require institutional treatment. Either a person is a drug addict or he is not, bearing in mind that the period of transition from a non-addict to a confirmed user is at best only a matter of weeks.

Mental disease is not an ordinary ailment which can be treated at home or in jail. Society recognises that the mentally ill must be forcibly confined and consequently we have enacted legislation providing for their committal to proper institutions. In the old days lunatics were punished because it was believed their infirmity was self-imposed through deliberate association with evil spirits. *Today we punish drug addicts because of their self-imposed addiction.* Yet we would regard as morally indefensible any attempt to punish an insane person, even though his affliction were self-imposed. For instance, one of the most prevalent forms of insanity, general paresis, is the direct result of self-imposed vice, namely venereal disease.

Although we have progressed to the stage where the law makes no distinction between the paretic patient, with his self-imposed disease, and any other type of insane person, we must admit no such progress when it comes to drug addiction. Yet the drug addict, even though he be a criminal who deliberately addicted himself, is essentially a psychopath whose addiction is actually due to his underlying mental instability. If we are prepared to accept the proposition that there is a close similarity between insanity and narcotic

addiction, then we should be willing to take the next step and provide the necessary legislation for the enforced committal and control of the drug addict.

It is the opinion of the writer that the O. & N.D. Act should be amended to provide that every addict, after certification as such by three physicians, should be committed to an institution for a period of not less than ten years, the first year of which term must be spent as an in-patient. Such institution should be operated by the Federal Government and staffed with specially trained and qualified physicians, psychiatrists, occupational, recreational and physical therapists, nurses and male attendants. The institution would provide the most modern hospitalization facilities and medical techniques for the withdrawal of the drug of addiction and restoration of the addict to normal physical health. Upon physical cure being completed there would follow the protracted process of mental rehabilitation. This would be accomplished through up to date methods of psychotherapy designed to treat and cure the underlying psychopathic condition which led the patient to become a drug addict in the first place. Such treatment would be combined with occupational therapy to ensure that the mental and physical energies of the patient were directed into channels best suited to his needs and most likely to make him into a useful member of society.

During his stay in such an institution the addict would not be cut off entirely from the outside world. He would be allowed visitors and mail, but only under the closest supervision so that no narcotics could be passed to him. Similarly, the place would be well guarded to prevent escape. Otherwise, the patient would have much freedom within the confines of the institution, being provided after working hours with wholesome entertainment, sports, games, reading, dramatics, study courses, etc. The old-time addict and recidivist would be segregated from the novice but apart from this all would be treated alike. The emphasis would be on mental cure and rehabilitation, training for a useful occupation, and there would be no suggestion whatever of punishment, even in the case of addicts transferred to the institution from the jails and penitentiaries.

The rule would be that no patient could be released under a minimum of one year, or longer if considered necessary in individual cases. Release would only be *on parole and to outside employment*. Unless the patient was willing to go to the job provided him and signed an undertaking to remain on that job and otherwise implicitly abide by the terms of his parole, he would not be released. The parole officers would be drawn from members of this Force with narcotic enforcement experience and others who had received similar training.

The parolee would be required to report weekly to the parole officer. He would not be allowed to associate with members of the criminal classes or to visit any persons or places where there was any possibility of narcotic contamination. He would not be permitted to change his place of abode or employment without prior report to and approval of the parole officer. The latter would pay frequent follow-up visits to see to it that the parolee was actually living up to the terms of his parole and also to supply him with the friendship, advice and personal encouragement he required. In addition, the parolee would be subject to periodic temporary admission to a narcotic clinic for complete medical re-check.

Parole would continue until the expiration of the ten year period, unless the individual violated the conditions of his parole, in which case a warrant would automatically issue for his re-committal for another ten years. In the event an addict were re-committed on two occasions he would be classed as incurable and sent for life to a special institution reserved for such cases. Even

then he would once more be physically cured and given an opportunity to follow a useful avocation, but permanently within the confines of the institution.

There are some who will say that this constitutes a very ambitious and expensive scheme. It is both. Nevertheless, it is no more costly than filling our jails and penitentiaries with addicts, paying policemen to catch them, and maintaining courts to sentence them. Furthermore it would eliminate the present terrific economic loss attributable to these persons, who are not only non-producers in our social order but parasites living off the others. It would greatly lessen crime and help reduce our criminal population. Surely no more progressive step could be taken by any country than one which would see her narcotic enforcement officers turn from the senseless task of pursuing the drug addict to punish him for his addiction, to the constructive role of narcotic parole officers whose duty it is to see that the physically cured and mentally rehabilitated addict is protected from the perils that beset him and enabled to play the part of a useful, law-abiding citizen.

Sometime after the foregoing had been written, the writer chanced upon a report on "Morphinism" by C. Edouard Sandoz, M.D., Medical Director, Municipal Court, Boston, Mass., which appeared in the "Journal of Criminal Law and Criminology" Vol. XIII, No. 1, May, 1922. Because they indicate that the conclusions reached by a police officer after many years spent in enforcing our narcotic legislation, are strikingly similar to those arrived at twenty-five years earlier by an eminent medical man in the United States, extracts from Dr. Sandoz's article are quoted below:

It is a matter of experience that a considerable number of relapses take place a short time after the patients are discharged. In many cases, in spite of all they have gone through, almost the first thing they do after release is to take to the syringe again. So, the longer supervision is extended after the habit has been broken, the better the chances are for a lasting cure. It is probable that, if the final results are so often unsatisfactory, it is due partly to the fact that patients are too soon allowed to shift for themselves. But, even if they succeed in keeping away from the drug for months, there still remains the danger of relapse into their former habits. The most frequent external cause for this is the resuming of associations with drug habitues. The recovery of their health after great suffering and the knowledge that a relapse means a return to misery are not sufficient to keep them away from morphine. They are doomed to yield to temptation if they resume their former associations.

Most critical authors hold the view, which seems to be correct, that relapses occur sooner or later in the great majority of all cases and that the outlook for a permanent cure is very dark.

In the last analysis, the main obstacle to the cure of morphinism is the patient's evident inability to renounce the use of the drug. He has not the so-called will power either to undergo the agony of withdrawal symptoms or, if weaned, to resist, in the long run, the lure of morphine. The logical conclusion is that, for his own good and for that of society, any morphinist ought to be considered irresponsible and, as such, committable. Commitment should cease when both mental and physical condition give hope of voluntary abstinence, but a provision ought to be made that, for years, he should submit periodically to a short time of confinement for observation and should be recommitted in case of relapse. Special institutions, which we do not possess, would be required. If morphinism continues to spread as it is now doing, the moment may come when laws will be enacted for this purpose.

The problem of drug addiction, and especially its remedy, is so complex that to treat it fully is beyond the scope of this paper. The remedy can be summed up in the simple formula: "Control the drug, control the addict."

But we have no law which allows the control of the addict as such. It would, no doubt, be difficult to obtain the enactment of such a law now, but, when the facts of morphinism are widely known and correctly interpreted, public sentiment might well be aroused and bring its pressure to bear on the legislature. Such a law, if enforced, would throw into relief the need of special institutions where addicts could be thoroughly weaned, sheltered for a sufficiently long time, and, afterwards, followed up systematically. If such institutions were available many addicts could be saved and would not be left to swell the hosts of thieves and prostitutes.

Attempts have been made at the institutional treatment and rehabilitation of drug addicts, notably the California State Narcotic Hospital at Spadra and, more recently, the U.S. Public Health Service Narcotic Farms at Fort Worth and Lexington. While a certain number of what might be called "permanent cures" have been effected, by and large these institutions do not appear to have accomplished the results their planners had in mind. Why? Because, the writer makes bold to suggest, too much emphasis has been placed on *cure* while in the institution and too little on *control* after release. This is a fatal mistake which we in Canada must never make. "Cure and control of the addict" is a good slogan, provided we give equal stress to each word and remember that without *control* over a lengthy period (if necessary for life where the patient proves himself incurable) *cure* in itself is a waste of time. It is suggested that these observations be borne in mind when reading the ensuing quotations.

The following comments on Fort Worth and Lexington are taken from the article written in 1943, entitled "A Prosecutor's Viewpoint on Narcotic Addiction", which has already been referred to above:

Hospitals are desirable and necessary experimental stations, and Public Health Hospitals offer the best known techniques for the treatment of the narcotic habit. We should be ever watchful, however, lest the admission of a great many underworld characters to such narcotic hospitals destroys their real purpose and character and becomes a frustration to law enforcement. These institutions then become "country clubs" where big or little criminals can sojourn for a few months in idyllic surroundings with much better food than is available to the law-abiding citizen.

Statistics for the U.S. Public Health Service predicated on the population of the narcotic farms as a whole convince me that prognosis with reference to effecting cures for the criminal type addict is poor as evidenced by the continued procession of ex-Lexington or ex-Fort Worth addicts who re-enter our criminal courts.

The following is taken from the 1936 "Report on Drug Addiction in California" by the Senate Interim Narcotic Committee:

After eight years of continuous operation we today feel justified in appraising our State Narcotic Hospital (Spadra) in the light of results achieved during that period. At the 1927 session of the legislature the State Narcotic Committee, having studied the problem for two years, introduced a bill providing for the creation of a hospital and farm for the care and treatment of drug addicts. It called for twelve months'

hospitalization for the first commitment and for the segregation of recurred or incurable addicts for a period of five to fifteen years on the farm.

Governor C. C. Young objected to the cost of such an institution, and at his request a different bill which carried no appropriation was introduced by others. It provided for a hospital with care and treatment for addicts for eight months, and supervision for an additional sixteen months, but no provision was made for those patients who after the course of treatment at Spadra recurred to the use of narcotics. Because of this oversight and its inevitable results, Spadra is said to have failed, and the demand is now being made by some legislators to have its facilities used for other purposes.

Now after eight years of operation, we at least understand the problem before us, and we know what we must do to solve it. We have succeeded with but 15% of the addicts treated, and we have discarded and washed our hands of the 85% of incurables who have recurred to the use of narcotics after the most thorough, painstaking course of treatment known to medical science. These incurable addicts are at liberty on the streets of our cities, spreading drug addiction among their associates and most of them following criminal pursuits in order to obtain the \$4. to \$5. they must spend daily for their supply of narcotics.

In solving the problem of the proper classification of addicts in relation to their care and treatment, it is vitally important that the curable be separated from the incurable if any measure of success is to be expected, and it is equally important that we arrive at a proper diagnosis in each case.

We realize that we must adopt the recommendation of the State Narcotic Committee of 1926. We must provide, in addition to our present hospitalization facilities at Spadra, a farm for incurables where recurred addicts may be committed for an indeterminate period of from five to fifteen years, at the discretion of the medical superintendent.

The most discouraging reports before us are indicated by the substantial percentage who recurred to the drug after resisting temptation for the sixteen-month period of parole. Sixteen addicts who were admitted to Spadra for a second "cure" all recurred to the use of narcotics for the second time during their parole period. We know now that two or three years is too short a time to "ameliorate the injury" wrought in the character of the addict by his addiction. It may be that the period of five or ten years is not enough. We do not yet know the answer, but we do see very clearly that the five to ten to fifteen year commitment for the recurred addict is the only possible solution. This plan should succeed unless the disintegration of character is irreparable. In that case we know that the cost of segregating these incurables on a narcotic farm for a very long period will prove much cheaper than permitting them to enslave and degrade others, and provide a lucrative market for international narcotic smugglers and our American illicit traffickers.

To the objection that the solution of the problem of drug addiction will be an added burden upon the taxpayers, we reply that the direct and indirect cost of crime resulting from drug addiction at present is much heavier than would be the cost of segregating incurable addicts on a narcotic farm for a long period of time.

The Federal Narcotic Farm at Lexington is the translation of the bill introduced by the late Stephen A. Porter into a reality. Assistant U.S. Surgeon General Walter Lewis Treadway is entitled to the credit

for the planning and supervising of this institution which is one of the finest and most complete in the country. Staffed by a group of scientific research men, we can expect a rapid advance in our knowledge of drug addiction and its effect upon human beings. The Lexington farm is a much more elaborate and scientific experiment than Spadra, and should achieve a higher percentage of permanent cures.

However, the U.S. Public Health Service has not profited by the mistakes which Spadra has made and remedied. We fear they have accepted the premise that drug addiction is purely a disease. We believe that the medical authorities are just as mistaken in calling addiction a purely medical problem as are the law enforcement authorities in claiming it is purely a police problem: both are partly wrong and partly right.

Their most serious mistake is their failure to provide an efficient follow-up system, an intelligent parole programme which would enable us to appraise the results obtained by their hospitalization. This knowledge would be worth all that the Lexington hospital has cost the nation, and would, we believe, confirm the results secured at Spadra, and thus provide us with the knowledge necessary for the final solution of the problem of drug addiction. The public health service, by not installing a follow-up parole system, is unable to evaluate the results obtained by their treatment of addicts, a most unscientific attitude.

Our experience at Spadra convinces us that the hospitalization programme at Lexington will have to be modified by a frank acknowledgement of the fact that approximately 84 per cent of their inmates are incurable, and the only solution is their permanent segregation.

The writer is convinced that the failure of institutional treatment to date may be laid to:

- (a) Failure to keep the addict in the institution for a sufficiently long initial period. (One to ten years is suggested, depending on the length and severity of prior addiction and upon the underlying causes responsible for the addiction.)
- (b) Failure to segregate youthful or other addict with but a short history of addiction, from the inveterate user whose long standing record of addiction offers scant hope of permanent cure.
- (c) Lack of stringent parole regulations with the full force of the law behind them.
- (d) Failure to provide adequate follow-up supervision upon release on parole, including:
 - (i) Lack of provision for suitable employment which would enable the former addict to earn an honest and adequate livelihood.
 - (ii) No steps taken to release the former addict to an entirely different environment, thereby making it impossible for him to clandestinely visit his former haunts and associates.
 - (iii) Lack of personal and constant check-up by properly trained parole officers, carried out over a period of years.
 - (iv) Absence of medical follow-up through enforced admission at regular intervals to government operated narcotic clinics.
- (e) Failure to immediately recommit, and for a much longer period, the individual who violates *any* provision of the terms of his parole.
- (f) Failure to recognize that the addict who reverts after proper treatment and follow-up supervision is *definitely incurable*, and to make provision for his committal for life. (The writer suggests such committal upon the occasion of the second reversion, thereby giving even the worst addict two separate opportunities to achieve a successful rehabilitation.)

APPENDIX O

Article written by R. S. S. Wilson, Former Superintendent,
Royal Canadian Mounted Police
August 16, 1952

DRUG CLINIC PLAN OPPOSED IN CANADA

I read with the greatest interest the report of the special committee on narcotics of Vancouver Community Chest and Council, which appeared in the July 30 issue of *The Vancouver Province*. I note that the committee is composed of a number of prominent citizens, included amongst whom are members of the legal and medical professions.

Because of this I feel it is most important and very much in the public interest that some criticism be levelled at the committee's plans before any attempt is made to carry them further.

It is my desire to take issue with the major recommendation of the committee calling for the establishment of narcotic clinics where drug addicts may receive their minimum required dosage of narcotics for a few cents a day.

I do so, not because I am out of sympathy with the overall aims and objectives of the committee which have been set out in its report a "comprehensive program aimed at destroying the illegal drug trade and rehabilitating the narcotic addict," but because I believe that the committee's recommendation is basically unsound and, if put into effect, will neither destroy the illegal traffic in narcotic drugs nor lead to the rehabilitation of that much-to-be-pitied person, the narcotic drug addict.

As one who has devoted many years of his life to the fight against the drug traffic, the writer has probably come to know addicts and the narcotic problem as well as any other person in this country.

It is because I have given years of thought, study, and first-hand observation to the narcotic problem that I feel qualified to question the line of attack proposed by the committee.

DRUG PROBLEM MORE ACUTE

As already stated, I am not out of sympathy with the aims of the committee. On the contrary, I am in complete agreement with many of the observations and conclusions they have reached. Furthermore, I am most thankful that someone has seen fit to stir up public opinion and call for definite action on the part of the responsible authorities.

There is no doubt that the narcotic problem is more acute today than ever before. Nor is there any doubt that the menace of drug addiction has continued to reach progressively younger age groups, until now we are faced with the appalling picture of mere children in their teens being embraced by its foul clutch.

Undoubtedly we must do something—and do it soon—to put an end to the curse of drug addiction and the Vancouver Community Chest and Council is deserving of the heartfelt praise of every right thinking citizen for its efforts to bring this about.

But the solution to the narcotic problem does not lie in the creation of Government clinics where narcotic injections are given to addicts at cost price. This amounts to nothing more than officially condoning drug addiction and placing the stamp of public approval upon a vicious and soul destroying habit, and comes close to realization of the addict's dream of a "barrel of heroin on every street corner."

It would no more stop drug addiction than the legal sale of opium in Government dispensaries has stopped the drug traffic or stamped out narcotic addiction in the Far East.

The sale of alcoholic beverages in Government liquor stores helps to control bootlegging but it does not stop it nor does it solve the problem of the chronic alcoholic.

ABSTINENCE ONLY SALVATION

The only hope for his salvation lies in complete abstinence. A person addicted to alcohol would never be satisfied with a "minimum required dosage" of liquor a day even if he could purchase it for a few cents at a Government-operated clinic. Certainly, he would be glad to take the alcohol so generously provided by the Government, but would promptly thereafter resort to the nearest illicit source for an additional supply.

In many ways—and the leading medical authorities are in agreement in this—there is a close similarity between addiction to alcohol and addiction to narcotic drugs. The same authorities likewise agree that there is only one cure in either case—complete and unqualified abstinence.

Contrary to what the committee seems to think, the addict who received a daily "shot" in a Government clinic would not be satisfied with this, but would seek an additional supply from illicit sources. In other words, the Government clinic would merely fill the role of another drug peddler.

Because it sold at cost; it would help keep the illegal price down, but because it did not furnish all the addict's requirements there would still be peddlers catering to his wants.

This means that the addict would continue to be an addict and would still be obliged to resort to crime to obtain the money with which to purchase narcotics.

The committee speaks of the legal administration at the clinic of an addict's "minimum required dosage". Who is to decide what constitutes any one addict's minimum required dosage? The addict?

It would seem so, as no medical practitioner could ascertain the exact quantity of a drug which, administered, say three times a day, would stabilize the addict unless the person in question were confined under close supervision for several days in a hospital.

I don't think the committee proposes doing this. At any rate, even assuming they do, how next do they plan on increasing the "minimum required dosage"?

EVER-INCREASING DOSES?

They apparently overlook the fact that the body rapidly develops tolerance to narcotics and because of this an addict requires ever increasing doses of his drug of addiction.

Unless he does he derives no relief (which he terms "pleasure") from the underlying emotional instability which led to his becoming an addict in the first place. If he can't get the additional drug at the clinic, the addict will seek it elsewhere, of that we may be sure.

Will the clinic cater to the addict's wants by giving him ever-increasing doses of the drug until he reaches the saturation point and dies of acute narcotic poisoning?

Where, before the war Canadian addicts used opium and morphine, they are now almost 100 per cent addicted to heroin, a drug so deadly in its habit

forming characteristics that its medical use is forbidden throughout the United States and in all hospitals in this country operated by the Department of Veterans' Affairs.

Does the committee propose administering heroin to our addicts? I can hardly credit the thought. But if they do not, and resort to the considerably milder morphine or codeine, the addicts will most definitely not be satisfied and, more than ever, will seek to get "high" or "steamed up" on illegally procured heroin.

To be quite frank, I cannot visualize the Government of Canada as it is obliged to do by international treaty, including in its annual estimates of internal consumption to the United Nations Narcotic Commission an item covering the legal administration of morphine, much less heroin, to Canadian drug addicts.

Insofar as heroin is concerned, the system of international control is so strict that countries, such as Canada, which do not produce it have to make a special request to the government of the exporting country.

Moreover, import certificates covering heroin can be issued only in favor of a government department and in this way the importing government assumes special responsibility in respect to heroin and undertakes to supervise strictly its subsequent distribution.

There are a number of other reasons I could advance, if space permitted, why the whole idea of government-operated narcotic clinics is, in my opinion, quite impractical.

PSYCHOLOGIC FACTORS VITAL

However, of far greater importance is the fact that we should remember that we are not treating with ordinary every-day sick people when we are dealing with drug addicts. As one eminent authority, Dr. J. H. W. Rhein, puts it:

Any effort to correct the evils of drug addiction must be based on a thorough understanding of the psychologic factors underlying the cause. The cause of development of the habit is inherent in the individual.

The drug addict is a psychopath before he acquires the habit. He is a person who cannot face, unassisted, painful situations; he resents suffering, physical, mental or moral; he has not adjusted himself to his emotional reactions. The most common symptom that requires relief is a feeling of inadequacy; an inability to cope with difficulties. These conditions call for an easy and rapid method of relief which is found in the use of drugs.

Habitual criminals are psychopaths, and psychopaths are abnormal individuals who, because of their abnormality, are especially liable to become addicts.

To such persons drug addiction is merely an incident in their delinquent careers, and the crimes they commit, even though they be to obtain money with which to buy narcotics, are not directly attributable to the fact that they are drug addicts.

More than 95 per cent of all drug addicts are the criminal addicts whose addiction in its inception and in its continuance is due to vice, vicious environment, and criminal associations. Experience definitely shows that in nearly all cases the addict was a criminal before he became addicted.

That is the actual situation as it exists here in Canada and it is useless to draw comparisons with other countries which are not faced with a drug

problem, as the committee does, and to say that such countries do not understand our concept of the criminal addict because their addicts "are not driven to crime in order to support their addiction".

One would gather from this statement that the committee believes that drug addicts were originally quite decent people who have been forced into a life of crime as a result of becoming addicted.

This is not so and the fact that in nearly all cases the addict was a criminal before he became addicted must be borne in mind if we ever hope to make a realistic approach to the solution of the narcotic problem in Canada.

It has been amply demonstrated in the past that addiction cannot be cured by the ambulatory method, that is, by the administration to the addict of gradually decreasing quantities of narcotics by a physician in his office.

This holds true not only for the main bulk of the addict population, which is made up of thieves, shop-lifters, prostitutes, forgers and such like underworld characters, but also for the tiny remaining noncriminal fraction.

Then how does the committee consider that its plan will, as it says, "rehabilitate the narcotic addict?"

I am afraid that the committee has accepted the negative view expressed by Jean Howarth in her column the day after the committee's report was published which was to the effect that a drug addict can never be cured and will remain such till the day he dies.

The committee certainly has not proposed any all-out plan for curing drug addiction, nor has it gone so far as to suggest that the institution of government-operated narcotic dispensaries will accomplish this.

From this one can only assume that they have little hope of being able to do anything for the addict other than letting him carry on with drugs supplied by the clinic.

In making the above statement I have not overlooked the committee's recommendation that a pilot medical treatment and rehabilitation centre be established together with a comprehensive followup service. But they only plan on handling volunteers in this clinic.

Might I point out that this statement is not in accord with the experience of the United States Public Health Service at their narcotic hospital in Lexington, Ky.

FORCED COMMITTAL BETTER

Here it has been found that far better results in effecting cures are obtained in the case of prisoners who are compulsorily committed for treatment and subsequently released on parole, than in the case of the "voluntary committals" who enter the hospital of their own volition and may leave whenever they please.

The latter (and the same would hold true here in Canada) largely treat the hospital as a "rest center" where they may with a minimum of physical discomfort cut down their drug habits to a manageable level.

While a comprehensive followup service is essential, this will not work without compulsion. The history of institutional treatment of drug addiction by the Federal Government in the United States not only shows that compulsory treatment is much more effective than voluntary treatment, but also that the lack of completely satisfactory results in that country is largely attributable to the absence of stringent and legally enforceable parole regulations, with recommitment the penalty for their violation, governing all cases after release from treatment.

In actual point of fact, a drug addict can be cured. However, due to the present lack of adequate provision in this country for the treatment of drug addiction, there is only one class of addict for whom there is any hope of a permanent cure.

These are the relatively few professional and business men who have families and business and social responsibilities. Such individuals, upon their release from a mental hospital or private sanitarium, return to their daily work and surroundings freed from the contaminating influence of contact with other addicts; they usually are of superior mental attainments and have a definite incentive—their home, families and business—to fight against any reversion to the habit.

In Canada there are today well over 150 members of one group alone who, although previously addicted, are now leading normal lives and have been doing so for periods of from 2 to 14 years. The successful results achieved in the Federal narcotic hospitals in the United States, and in this country when dealing with cases where there is no underworld association, proves conclusively the incorrectness of the general belief that a drug addict can never be cured.

CONCENTRATE ON ADDICTS

If we accept the proposition that the narcotic problem is capable of solution, and no right thinking man would wish otherwise, how then should we proceed?

It is my definite considered opinion that drug addiction as we know it today, with all its attendant crime and evil, can be wiped out in Canada within a very few years if we are but willing to face the facts and attack the problem from a realistic point of view.

We can stop the drug traffic in Canada if we will do three things:

- (1) Maintain international and domestic control over the legal traffic.
- (2) Continue to wage war on narcotic smugglers and internal traffickers.
- (3) Cure and permanently control the drug addict.

It is the writer's contention that narcotic addiction must be regarded and treated in exactly the same manner as we now regard and treat the various forms of mental disease.

The only difference is that there are no "mild forms" of drug addiction which do not require institutional treatment.

Mental disease is not an ordinary ailment which can be treated at home or in jail. Society recognizes that the mentally ill must be forcibly confined and consequently we have enacted legislation providing for their committal to proper institutions.

In the old days lunatics were punished because it was believed their infirmity was self-imposed through deliberate association with evil spirits. But today we would regard as morally indefensible any attempt to punish an insane person, even though his affliction were self-imposed, as for example general paresis, which is a direct result of self-imposed vice, namely venereal disease.

However, we have made no such progress when it comes to drug addiction. Yet the drug addict, even though he be a criminal who deliberately addicted himself, is essentially a psychopath whose addiction is actually due to his underlying mental instability.

If we are prepared to accept the proposition that there is a close similarity between insanity and narcotic addiction, then we should be willing to take the next step and provide the necessary legislation for the enforced committal and control of the drug addict.

It is the opinion of the writer that the Opium and Narcotic Drug Act should be amended to provide that a drug addict, after certification as such by three physicians, must be committed for a period of not less than 10 years to a narcotic hospital operated by the Federal Government.

The act should further provide that the first year of the 10-year committal period must be spent in the hospital as an in-patient, but that after the expiration of the first year the addict would be eligible for release on parole.

The narcotic hospital would be competently staffed and the emphasis would be on mental cure and rehabilitation and training for a useful occupation. There would be no suggestion of punishment.

The hospital would provide the very latest medical techniques for withdrawal of the drug of addiction and restoration of the patient to normal physical health.

The second and more protracted stage of mental rehabilitation would be accomplished through up-to-date methods of psychotherapy designed to treat the underlying psychopathic condition which led the patient to become an addict and to reeducate and reconstruct his personality so that he can learn to adapt himself to his emotional reactions.

Combined with this treatment would be occupational therapy to ensure that the patient's physical and mental energies were directed into channels best suited to his needs and most likely to make him into a useful and self-supporting member of society.

After the expiration of 1 year in the hospital the patient would be released, but only on parole and to outside employment. Unless the patient were willing to go to the job provided him and signed an undertaking to remain on that job and otherwise to abide implicitly by the terms of his parole, he would not be released.

Such terms would provide that the parolee report regularly to the parole officer, that he not associate with members of the criminal classes or visit persons or places where there was any possibility of narcotic contamination, that he not change his employment or place of abode without prior report to and approval of the parole officer, and that he undergo periodical medical rechecks.

"LIFE" AFTER TWO RECOMMITTALS

Parole would continue until the expiration of the 10-year period, unless the individual violated the conditions of his parole, in which case a warrant would automatically be issued for his recommittal.

In the event an addict were recommitted on two occasions he would be classed as incurable and sent for life to a special institution reserved for such cases. There he would once more be physically cured and given an opportunity to follow a useful avocation, but permanently within the confines of the institution.

APPENDIX P

Translation:

AN OUTLINE OF THE FRENCH LEGISLATION ON NARCOTIC DRUGS

By Mr. Charles Vaille, representative of France
on the United Nations Narcotics Commission.

The Lafarge Affair which impassioned France during the July Monarchy caused the legislator to enact a general law on poisonous substances. It was the law of July 19, 1845, the provisions of which, as amended by the law of July 12, 1916, the law of December 20, 1933, the order in council of July 29, 1939, and the law of December 24, 1953, were inserted in the Code of Health (articles 626 to 630). The law of 1845 does not in fact create a truly special control. It is a repressive law, which merely stipulates penalties against those who break the regulations which, according to its provisions, the government may enact from time to time.

This is an appropriate solution, as the executive is in a better position than parliamentary Assemblies to follow scientific developments which sometimes are quite rapid in this domain. And it is indispensable that this control—which can only be effected by the executive—be immediately adapted to this evolution. The first Regulation of Public Administration, pursuant to this legislation, was made on October 29, 1846. It remained in force during almost 75 years, was replaced by the Regulation of September 14, 1916, to which was substituted the Regulations of November 19, 1948.

Concerning narcotic drugs, control by regulations means not only the publication of such regulations, but also controlling their enforcement. This prevention is two-fold: that of illegal traffic proper, and that of infractions against lawful traffic.

ILLEGAL TRAFFIC

The prevention of illegal traffic is assured by the penalties provided for the offences which constitute such illegal traffic, and by the activities of the specialized police services.

Penalties—Articles 627 to 630 (see Appendix) of the Code of Public Health provide for penalties applicable to offences concerning narcotic drugs, and define a certain number of offences other than those committed against the regulations made by the public administration concerning this matter.

The penalties are as follows: a prison term of 3 months to 5 years and a fine ranging from 360,000 to 3,600,000 francs. Those penalties may be doubled when the offence consists in manufacturing illegally narcotic drugs or in supplying such drugs to a minor.

This last provision was introduced by the law of December 24, 1953, in order to assist in preventing the expansion of juvenile toxicomania, the expansion of which in foreign countries was shown in a precedent chapter.

This is rather exceptional in French law: a person attempting to commit an offence is liable to the same penalty as the one who has actually committed it; the same applies to conspiring or associating for the purpose of committing an offence.

The following are considered as infractions:

- the use of narcotic drugs in the presence of other persons,
- facilitating the use of narcotic drugs to any other person, by any means,
- obtaining narcotic drugs by means of a fictitious or complacent prescription,
- knowingly giving narcotic drugs upon presentation of such a prescription.

The offences defined in the Code of Health are intentional infractions; this is not the case with infractions to the Regulations of public administration, that is to the Decree of November 19, 1948, and to the enforcing regulations made thereunder. Such infractions are offences against police regulations; they are strictly material infractions, and consequently the offender cannot claim that he acted in good faith. Such offenders can be punished by the very fact that they have committed the prohibited action. (Court of Appeal of Montpellier, October 13, 1932; Court of Appeal of Bordeaux, December 16, 1952, etc. . .).

In enforcing the regulations concerning narcotic drugs, the law punishes fraud as well as negligence or ignorance of legal texts.

LAWFUL TRAFFIC

The lawful traffic of narcotic drugs is regulated by the Decree of November 19, 1948, and the regulations made thereunder. It entails a rather complicated set of regulations, some of the most important of which will be explained for physicians and for the purpose of prevention.

One of the main principles of the Decree is that a narcotic drug should be followed since its origin until it has disappeared, in order to prevent it from disappearing into illegal traffic. Concerning importation, the processing of raw materials and of medical drugs, and their non-compliance with controlling regulations which permit them to be permanently controlled, are imposed upon practitioners.

When we move from the factory to the druggist's laboratory, we can see how the regulation attempts to prevent a certain number of misuses.

In order that thieves will not be tempted to steal them, narcotic drugs must be kept in a locked cabinet. This cabinet must not contain any other substances, except the poisons listed in Table A, in order to restrict persons from going to and from this cabinet. Any quantity of narcotic drugs found outside the cabinet must be confiscated by the repressive authorities, excluding, however, those products as are detained by sick persons under a regular prescription. Even the physicians must abide by this provision, excluding, however, the contents of their emergency kit.

In order to remedy to false wholesale purchases, an order booklet of narcotic drugs has been instituted and distributed by the Order of Pharmacists. By means of this booklet, the accountancy of the supplier may be compared against that of the purchaser.

Before this booklet, it was very easy to obtain a wholesale supply of narcotic drugs by using, for instance, false prescriptions and false seals. During the Occupation, the "Forces Françaises de l'Intérieur" had no difficulty in obtaining all necessary medical drugs with the complicity, as must be admitted, of one of the controlling officers.

Narcotic drugs can be issued to the public only under a physician's prescription in conformity with official regulations. It would be dangerous to overstep this fundamental principle. Among the many tricks which addicts have used in an attempt to bypass this obstacle, we will cite the following, which has misled several druggists.

A customer presents a regular prescription asking for suppositories containing narcotic drugs. This prescription is filled. A few hours later the customer comes back and claims that by mistake the box was laid on top of a radiator and that the suppositories are useless. He asks that another box be kindly given to him pending the next visit of the physician who will certainly renew his prescription, and the trick is over; this will bring the druggist before the courts, because this person was an addict well known to the Police with whom he regularly gets into trouble.

The most effective regulations concerning prevention are those which instituted the "stub-booklet" for prescriptions and the seven day Rule.

The Stub-Booklet—A minority of physicians were quite vocal against the use of this booklet. Among them were men of good faith who saw in it nothing but a new measure of "administrative red tape". Others had less honest reasons to oppose it.

The necessity of using this stub-booklet for obtaining narcotic drugs is originally responsible for the disappearance of false prescriptions. In Paris, before it was instituted, at least 50% of prescriptions for narcotic drugs were false and represented more than half of the total consumption of those drugs. This proportion was less in the rest of the country, but nonetheless it was quite considerable.

The stub-booklet has interesting indirect results: it is a defensive weapon against the drug-addict who pesters him; he need only point out that his booklet is numbered and registered under his name with the Order of Physicians, that his prescriptions are classified and controlled regularly, that the name of the patient must appear on the stub, and consequently complacent prescriptions cause the physician and the client to be immediately brought before the courts, etc.

It must be admitted that it restrained the "prodigality" of certain physicians.

The Seven Day Rule—The immediate purpose of this Rule is to prevent the patient from keeping at his disposal important quantities of narcotic drugs which he could use without medical supervision. A prescription must not provide for a treatment beyond a period of seven days. (In some countries, this is restricted to three days.) After this period of time, the physician must decide whether or not he continues to administer drugs.

This Rule entails capital results as far as prevention is concerned. In practice, it is a very effective barrier against the expansion of abusive use of narcotic drugs. Thus, in France, all lawful consumption of narcotic drugs is subjected to a permanent medical document. One can avoid this obligation only by committing an offence.

The drug-addict who simultaneously consults several physicians without notifying them of this fact, and who obtain narcotic drugs during a period of time covered by a former prescription commits an offence and may be prosecuted.

The 1948 Decree softened the former seven day Rule by enabling the physician to transgress it, if he does so knowingly and if he assumes the technical responsibility for so doing. He needs only to show on the new prescription a reference concerning the former prescription.

This measure removed from the former Rule what appeared to be a restriction imposed on the right of prescribing drugs. It enables a physician to adapt his therapy to the eventual evolution of his patient's illness, but such over-lapping is justifiable only if it is exceptional.

It is easy to refute the objections put forward against this Rule; but the following deserve consideration: "In the case of incurable cancers, for instance, this regulation compels the physician to visit his patient, without practical purpose, at least once a week."

This objection, which is heard very often, is not any sounder than the others. Administering narcotic drugs to persons dying from cancer will but appease a particularly tragic end. The physician can obtain this result only through a judicious choice and dosage of the analgetics to be administered. Otherwise, with the habit and if the patient is left to his whims, more tragical situations are encountered, because nothing more will relieve him, and the need for drugs adds even greater suffering to the existing organic pains. And

what about the physician who "abandons" his patient? From a purely human point of view, the regular visit of a good physician brings upon his patient a well-known feeling of comfort; and is that not one of the most magnificent aspects of medicine?

Rules Concerning Prescriptions—A physician may prescribe narcotic drugs only after he has examined the patient. It may be surprising to find such a provision in a Rule. It was inserted at the request of some advisors of the Minister of Justice who, while studying narcotic cases, were astounded at the number of prescriptions issued without the patient being examined, made out at the request of the patient and handed out to third parties, etc. Imprudence in this domain is incredible: for instance, the case of this drug-addict who goes to a physician at the time of consultations. He asks him to attend immediately his mother who is suffering from Pott's disease, and was suddenly stricken with unbearable pains while in town. The waiting room is filled with patients, and the physician states that it is impossible for him to leave immediately; then the drug-addict asks, in the meantime, for a prescription of Pethidine, evidently giving a fictitious name and address; as soon as the physician is through with his consultation, he will realize this deceit.

It would be useless to attempt to describe all the tricks that are used, as they are countless and new ones are discovered.

While writing his prescription, the physician must observe the following rules: date it; sign it; mention legibly his name and address, the name and address of the beneficiary, the directions for using the medicine. The doses and the number of units must be inserted in full. Every one of these provisions is an obstacle to fraud.

As a corollary to the narcotic drugs cannot be renewed.

Emergency Supply to Practitioners—Physicians are authorized to obtain and retain narcotic drugs within the limits of a supply for emergency needs. The fact of using narcotic drugs, thus acquired, for purposes other than those for which they were intended, constitutes an offence.

Physicians must obtain their supply from only one pharmacist, which they have selected, in the locality where they reside. Every three months, the supplying druggists send to the "Directeur Départemental" of Health a statement of the narcotic drugs which they have thus delivered.

ENFORCEMENT OF REGULATIONS

In France, the Pharmacist-Inspectors of Health are mainly in charge of controlling the enforcement of this regulation. The results of their investigations are centralized at the Office of the Narcotic Drugs of the Department of Public Health (Central Service of Pharmacy).

The results obtained in France depend on the technical qualifications of the officers in charge of this control.

Title III, which is the last in the decree of November 19, 1948, deals with general dispositions which apply also to the substances mentioned in the three tables. It relates to inspection, and to the investigation of offences.

Pharmacy inspectors are not the only ones empowered to attend to the enforcement of the provisions of this decree. They are also assisted by the inspectors and agents of the "Service de la répression des fraudes", the mayors and police commissioners. But these two last-named authorities can only act with the assistance of an inspector of pharmacies, or, in his absence, of a pharmacist appointed by the Prefect. In order to properly fulfill their duties, they indeed must have the assistance of a technician.

With the help of the inspector of pharmacies and the pharmacist appointed by the Prefect, the mayors and police commissioners are empowered to visit the dispensaries, medical stores of physicians and veterinarians, warehouses, pharmacists' stores and merchandise agents processing or distributing poisonous substances, the laboratories where they are treated for the purpose of extracting alkaloids or transforming them into pharmaceutical preparations, herbalists' shops, grocery stores, hair-dressing or perfume shops and, generally, all places where the substances concerned are manufactured, stored or sold. (In fact, only pharmacists or manufacturers may have narcotic drugs in their possession. The control over other establishments concerns other poisonous substances.)

The inspecting officer requests the receipt of the statement which was made by the person who deals in substances mentioned in Table A or who is engaged in a business where such substances must be used, and when necessary, the authorization to manufacture, process, extract, prepare, retain in his possession, offer, distribute, purchase, sell, import and export substances mentioned in Table B (narcotic drugs) or deal with them as a broker.

In the absence of such justification, the products found to be in breach of the regulations are confiscated, and if one or more substances mentioned in Table B are also found, the Prefect orders the closing of the establishment.

The inspecting officer checks the records to ascertain whether they are regularly kept and whether existing quantities correspond to the figures as shown therein.

If infractions are discovered, a report is made showing the operations that were effected.

The officer who drafted this report sends it to the Attorney of the Republic, and he also transmits a copy thereof to the Prefect.

THE REGULATIONS ARE ADJUSTED

Annual Program—On the basis of the inspection work effected by Pharmacy, Police and Customs officers, the Minister of Health determines each year his policy toward narcotic drugs, with the assistance of an inter-departmental commission which includes, besides representatives of all services concerned, experts particularly competent in this matter.

The quantities of narcotic drugs to be manufactured are set each year. The number of manufacturers is reduced to the strict minimum. It is thus easy to effect a proper control, and the *de facto* monopoly thus granted in conformity with Conventions is one of the best guarantees of the trust which can be placed in the honesty of the manufacturers.

Decrees of Exoneration—The regulations concerning poisonous substances provide for exonérations respecting the issuing without a prescription of medicinal preparations containing weak doses of toxic substances. Under the provisions of the "Law of Germinal" (The *Loi de Germinal an XI* regulated pharmacy until the enactment of the Law of September 11, 1941, which is presently in force in France), no medicament could be issued without a physician's prescription, and it had been proven that this rule, which is impossible to enforce, was being violated without discrimination. Exonerations established order in this matter.

In the case of narcotic drugs, more important factors than the toxicological criterion were encountered.

Thus some preparations were exonerated in view of the fact that, due to their nature, they could not cause any unlawful use; this is the case with liniments and lotions (the issuing is possible with an ordinary prescription, and it can be renewed).

For a long time, this was the case with suppositories which, in limited doses and quantities, could be issued without a prescription until it was found out that they caused misuses.

Suppositories with basic ingredients of opium extract continued to be exonerated; but they were limited to a total weight of excipients in order that misuse could be restricted.

More examples could be cited to show that, in this domain, experience alone can prove whether a regulation is sound, and that sufficient data must be obtained to indicate a "national balance-sheet".

THE ROLE OF PROFESSIONAL ORDERS

The French legislation stipulates that physicians as well as pharmacists may practice only when they have been registered with the Order of Physicians or the Order of Pharmacists.

The purpose of these organizations is to protect the moral interests and the honour of the profession. They may also deal with any matter concerning the solidarity and superannuation of physicians and pharmacists. These organisms were created in 1945, and they are vested with important jurisdictional powers. The Councils of the Order are constituted in a disciplinary Chamber, and they are presided over by a magistrate. When a practitioner is summoned to appear before the disciplinary Chamber, he may ask the assistance of a colleague or of a lawyer. The Council of discipline of the Councils of the Order may, when needs be, hand down one of the following punishments:

1—a reprimand.

2—a blame entered in the record.

It may also inflict the following punishments, and ask the Prefect to enforce them: prohibition to practise during a limited period; total prohibition to practise. These sanctions may be appealed from before a national Council of the Order.

As for pharmacists, the Order-in-Council of May 5, 1945, created the Order of Pharmacists. Presently, the legislation relating to the Order of Pharmacists is contained in articles 520 et sequ. of the Code of Public Health.

When a physician or a pharmacist breaks a regulation respecting narcotic drugs, whether it be an outright offence or a professional error, the Minister of Health never fails to cause the person concerned to be summoned before the disciplinary Councils. Excellent results have been obtained from the functioning of these institutions, in view, particularly, of the rapidity with which they can penalize a professional, whereas it takes indeed a longer period for tribunals to do so.

As an example of sanctions imposed by the Order of Pharmacists, we will cite the following:

Interdiction from practising:

- during 7 days, 15 days, 4 years (Doc. phar. 108);
- during 4 years (Doc. phar. 280);
- during 8 days, 5 years (Doc. phar. 287, 557, 693);
- during 2 months, 1 month, 8 days (Doc. phar. 315, 519, 577, 665, 726, 751);
- during 15 days (Doc. phar. 345, 401, 557, 601, 693);
- during 1 month (Doc. phar. 419, 501, 577, 639, 693, 717);
- during 8 days, 2 years (Doc. phar. 452);
- during 6 months (Doc. phar. 519);
- during 3 years (Doc. phar. 751);
- during 1 year (Doc. phar. 776);

A blame entered in the record (Doc. phar. 108, 130, 188, 213, 214, 298, 315, 401, 419, 452, 454, 501, 601, 665, 693, 726, 751, 776);

A reprimand (Doc. phar. 108, 134, 147, 188, 214, 280, 298, 315, 345, 401, 415, 452, 484, 501, 519, 579, 601, 629, 665, 693, 717, 726, 751, 776);

The following cases were dismissed: (Doc. phar. 108, 147, 213, 289, 315, 345, 401, 419, 484, 501, 519, 665).

TREATMENT OF DRUG ADDICTS

Any person accused of an offence under these articles shall appear before an examining magistrate who may, according to the provisions of Article 64 of the Penal Code, order an expert's opinion on the degree of responsibility of such person. In the case of a person suspected of toxicomania, the examination shall be performed by a psychiatrist who shall transmit his findings to the court. If it is found that the accused has used narcotic drugs without legitimate motive, Article 628 Ter provides for his or her compulsory disin-toxication in a specialized establishment on the order of the examining magistrate.

The regulation of public administration, which shall determine the conditions of admission, of treatment and of discharge of addicts, as well as the apportionment of expenses, has not yet been published. A Commission appointed by the Minister of Justice and the Minister of Public Health and Population, composed of a majority of representatives of the medical body, shall give their agreement to the conclusions now being planned on the matter by the services of the two Departments.

At any rate, the admission of the principle of compulsory medical treatment for drug addicts shows an important progress in repressing toxicomania. It is probable that, as in federal hospitals of the United States for the treatment of drug-addicts, voluntary patients may be admitted under certain conditions. Medical doctors in France enjoy by tradition full liberty to decide on the treatment of their patients, and such a principle will certainly be respected in the case of medical treatment of drug-addicts in an official institution. However, the medical staff of the hospital shall be appointed by the Government.

CONCLUSION

As a summary of the methods successfully employed in France for the prevention of toxicomania, one could state that the essential principle was to control very closely any substance designated under the name of narcotic drug "from its origin until its disappearance", and, in fact, prevent it from being misused.

The French legislation and regulations are essentially of a preventive nature, and they are based on a most simple principle: "No narcotic drugs, no toxicomaniacs". Repressive methods and rigorous enforcement of penalties are the most efficient measures against drug traffickers and illegal trafficking. The measures intended to repress illicit practices of legal traffic have given particularly good results. The use of a stub-book and the observance of the seven day Rule have reduced on a large scale abusive use of the legal traffic. The authorities have enacted such regulations by taking into particular account the medico-social aspects of toxicomania in France. By prescribing the compulsory treatment of drug-addicts in specialized establishments, the Law of December 24, 1953, will fill the only gap remaining in a preventive system of which one could say that it affords an efficient solution to a problem which, if it is not very acute in France, nevertheless constitutes a possible danger for modern society.

Code of Pharmacy

ARTICLE 626

Any person infringing the regulations of public administration concerning the sale, the purchase or the use of poisonous substances shall be liable to a fine of 24·000 to 720·000 francs and to a term of imprisonment of six days to two months, or to either penalty only.

ARTICLE 627

Any person who has infringed the provisions of such regulations concerning substances classified as narcotic drugs under the regulations shall be liable to a term of imprisonment of three months to five years and a fine of 240·000 to 2·400·000 francs, or to either penalty only.

Any person who attempts to commit any of the offences mentioned in the preceding paragraph shall be punished as if he had actually committed the offence. The same will apply to conspiracy or agreement for the purpose of committing such offences.

The penalties prescribed in the two preceding paragraphs may be imposed even when the various acts constituting the elements of the offence have been accomplished in different countries.

The same penalties shall be imposed upon those who have used in the presence of others the said substances or who have facilitated to other persons the use of same for valuable consideration or gratuitously, either in procuring premises for that purpose or by any other means.

The courts may, furthermore, in any case mentioned in the preceding paragraphs, interdict an offender the use of his municipal rights for a period of one to five years.

The courts may pronounce local banishment (*interdiction de séjour*), during a period of not less than five years and not more than ten years, against persons found guilty of having facilitated to others the use of the said substances, either in procuring premises for such purpose, or by any other means.

The premises where narcotic drugs are used before other persons, and the premises where the said substances are illegally manufactured shall be assimilated to places notoriously known as disorderly houses, in conformity with paragraph 2 of article 10 of the Decree of July 19-22, 1791.

ARTICLE 628

The penalties described by Article 627 shall be imposed:

Onto persons who, by means of fictitious or complacent prescriptions, have obtained or attempted to obtain one of the poisonous substances mentioned in the said article.

Onto persons who, knowingly, on presentation of such prescriptions, have delivered the said substances, as well as onto those who, without legitimate motive, had on their person any such substance.

ARTICLE 628 Bis

The penalties prescribed by Article 627, including local banishment, shall be doubled when the offence consists in the illegal manufacture of poisonous substances mentioned in the said Article or the illegal growing of plants containing active principles of such substances.

The same will apply when the use of the said substance has been facilitated to a minor or when the said substances have been delivered to a minor under conditions provided for in Article 628.

ARTICLE 628 Ter

Persons known to make use of narcotic drugs and accused of any offence under Article 627 and 628 may be compelled, by order of the examining magistrate, to undergo a disintoxication treatment in a specialized establishment, under conditions which shall be determined by an order of public administration passed on the report of the "Garde des Sceaux" (Minister of Justice) and of the Minister of Public Health and Population, in conformity with the advice of a commission the members of which shall be appointed by a joint order of the two above-mentioned Ministers.

The majority of the members of this Commission shall consist of representatives of the medical body. The advice of the said Commission on the proposed order of public administration hereabove mentioned shall be valid only if half of the members plus one present at the taking of the final vote are representatives of the medical body.

The same order of public administration shall determine under what conditions the States shall assume the costs of the disintoxication establishments, together with the cost of hospitalization and treatment.

Any person who does not comply with the above-mentioned order is liable to a term of imprisonment of not less than six days and not more than two months, and a fine of 24·000 to 720·000 francs. These penalties shall not be concurrent with those imposed under Articles 627, 628 and 628 Bis.

ARTICLE 629

In all cases provided for in this chapter, the courts may order confiscation of the seized substances. But such confiscation shall not be pronounced when the offence has been committed in a pharmaceutical dispensary if the offender is only the responsible manager, unless the owner of the dispensary has been acting as an accomplice.

In cases provided for in the first paragraph of Article 627 and in the second paragraph of Article 628, the courts may prohibit the guilty person from practising the profession in respect of which the offence has been committed, during a period not exceeding two years. Such period shall be increased to five years in cases provided for in Article 628 Bis, and for the repetition of the offence.

In cases provided for in the fourth paragraph of Article 627, the courts shall order the confiscation of substances, utensils, materials, furniture and personal property found on the premises, as well as the prohibition, for the offender, during a period that the courts shall determine, to practise the profession under cover of which the offence has been committed.

In cases provided for in the first paragraph of Article 628 Bis, the confiscation of materials and fittings which were used for the manufacture and transportation of substances shall be ordered.

Any person who contravenes the order prohibiting him from practising his profession, as pronounced under paragraphs 2 and 3 of this Article, shall be subjected to a term of imprisonment of not less than 6 months and not more than two years, and a fine of at least 240·000 francs and not more than 2·400·000 francs.

ARTICLE 630

The penalties prescribed in Articles 626, 627 and 628 shall be doubled in the case of a second offence, under the conditions provided for in Article 58 of the Penal Code.

APPENDIX Q

NUMBER OF PROSECUTIONS ENTERED YEARLY
DURING PERIOD JANUARY 1, 1940 TO DECEMBER 31, 1954

Year	Male	Female	Total	Convictions	Withdrawals	Dismissals
1940.....	124	10	134	81	44	9
1941.....	74	77	151	116	23	12
1942.....	53	8	61	37	14	10
1943.....	84	6	90	58	17	15
1944.....	83	19	102	80	11	11
1945.....	44	36	80	48	2	30
1946.....	88	26	114	71	20	23
1947.....	170	44	214	136	59	19
1948.....	133	62	195	119	50	26
1949.....	173	55	228	127	75	26
1950.....	115	54	169	100	53	16
1951.....	95	49	144	85	36	23
1952.....	112	30	142	71	43	28
1953.....	110	53	163	101	37	25
*1954.....	131	40	171	110	36	25

There were nine cases still before the Courts at December 31.

APPENDIX R

TORONTO CITY POLICE DEPARTMENT

NUMBER OF PERSONS CHARGED WITH BREACHES OF THE OPIUM AND NARCOTIC DRUG ACT
1946 TO APRIL 20, 1955, INCLUSIVE.

—	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955
Male.....	89	76	70	60	63	42	51	48	52	21
Female.....	63	43	41	35	30	22	16	33	17	11
Total.....	152	119	111	95	93	64	67	81	69	32
Withdrawn.....	23	25	23	18	10	11	9	19	9	5
Discharged.....	27	10	16	8	17	11	10	4	5	1
Fined and Imprisoned.....	102	84	72	69	66	42	44	58	51	19
Awaiting Trial.....							4		4	7
Total.....	152	119	111	95	93	64	67	81	69	32

Male Offenders range in age from 19 to 77 years—Average 40 years.
Female Offenders range in age from 18 to 65 years—Average 33 years.

APPENDIX S

TABLE I—FIRST ADMISSIONS

Year	Drug Psychosis	Drug without Psychosis	Total First Admissions to all Ontario Hospitals
1948.....	16	9	3,032
1949.....	13	6	3,056
1950.....	8	14	3,287
1951.....	19	6	3,568
1952.....	21	13	3,684
1953.....	24	14	3,982
1954.....	20	5	3,922

TABLE II—IN RESIDENCE

Year	Drug Psychosis	Drug without Psychosis	Total in Residence in all Ontario Hospitals
1948.....	8	8	16,459
1949.....	11	2	16,754
1950.....	10	1	17,240
1951.....	11	2	17,852
1952.....	12	1	18,393
1953.....	10	2	18,957
1954.....	11	3	19,581

APPENDIX T
COMPARISON

BY PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.
Calendar Year 1945

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession.....	5	.....	5	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	5
New Brunswick.....	Possession.....	2	.....	.....	1	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	2
	Section 10.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	3	1	.....	1	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	3
Quebec.....	Possession.....	20	.....	12	4	1	.....	2	.....	.....	1	.....	.....	.....	.....	.....	20
Ontario.....	Section 6.....	1	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Possession.....	63	.....	39	14	4	1	5	.....	.....	.....	.....	.....	.....	.....	.....	63
	Selling.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	65	.....	40	15	4	1	5	.....	.....	.....	.....	.....	.....	.....	.....	65
Manitoba.....	Possession.....	6	.....	2	1	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	6
Saskatchewan.....	Possession.....	1	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
Alberta.....	Possession.....	11	.....	9	1	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	11
	Selling.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	12	.....	10	1	.....	.....	.....	1	.....	.....	.....	.....	.....	.....	.....	12
B.C.....	Possession.....	46	.....	18	4	1	.....	17	2	2	1	1	.....	.....	.....	.....	46

Note:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200 was mandatory under the provisions of the Act.
2. Concurrent convictions are not included in these totals.

COMPARISON
BY PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1946

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession	7		6	1												7
New Brunswick.....	Nil																
Quebec.....	Possession	22		9	3	4		4									22
	Transporting	1		1													1
	Selling	1															1
	Section 6	2		1	1												2
	Totals	26		11	5	4		4	2								26
Ontario.....	Possession	111		65	28	5	1	12									111
	Selling	2							2								2
	Totals	113		65	28	5	1	12	2								113
Manitoba.....	Possession	18		13	2			1	2								18
	Selling	1		1													1
	Totals	19		14	2			1	2								19
Saskatchewan.....	Possession	4		3	1												4
	Section 10	1	1														1
	Totals	5	1	3	1												5
Alberta.....	Possession	15						1	1								15
B.C.....	Possession	60		23	17	1		13	3	1	3						60

Note:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
2. Concurrent convictions are not included in these totals.

COMPARISON

By PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1947

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Section 10.....	1	1														1
New Brunswick.....	Nil.....																
Quebec.....	Section 6.....	7		7	1												7
	Selling.....	1		13	2	1		1	2								1
	Possession.....	19		13													19
	Totals.....	27		20	3	1		1	2								27
Ontario.....	Possession.....	91		30	31	9		15	6								91
	Selling.....	9		2	1			4	1	1							9
	Totals.....	100		32	32	9		19	7	1							100
Manitoba.....	Possession.....	16		10	2			2	1			1					16
	Selling.....	1						1									1
	Totals.....	17		10	2			3	1			1					17
Saskatchewan.....	Section 10.....	1						1									1
	Possession.....	5		3	2												5
	Totals.....	6		3	2			1									6
Alberta.....	Possession.....	12		6	2	1		2	1								12
B.C.....	Possession.....	88		33	27*	3		15	5		5						88
	Transporting.....	3									1						3
	Section 6.....	1									1						1
	Totals.....	92		33	27	3		15	5		7		2				92

NOTE:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.

2. Concurrent convictions are not included in these totals.

* One of these was also awarded 5 strokes of paddle.

COMPARISON
By PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1948

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Nil.....																
New Brunswick.....	Nil.....																
Quebec.....	Possession.....	20		5	4			2	3	1	3	2					20
	Transporting.....	1		1													1
	Totals.....	21		6	4			2	3	1	3	2					21
Ontario.....	Possession.....	92		22	26	7	4	22	7	3	1						92
	Selling.....	5		1				2		2							5
	Totals.....	97		23	26	7	4	24	7	5	1						97
Manitoba.....	Possession.....	3		1	2												3
Saskatchewan.....	Section 10.....	1	1														1
	Possession.....	7				1		3									7
	Totals.....	8	1	1	2	1		3									8
Alberta.....	Possession.....	14		9	2			1	1	1							14
	Selling.....	2										1					2
	Totals.....	16		9	2			1	2	1		1					16
B. C.....	Possession.....	111		42	49	3		10	4		1		2				111
	Selling.....	7			1			3		1	2						7
	Transporting.....	1			1												1
	Totals.....	119		42	51	3		13	4	1	3		2				119

NOTE:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
2. Concurrent convictions are not included in these totals.

COMPARISON

BY PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1949

Province	Type of case	No. of cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession.....	1		1													1
New Brunswick.....	Selling.....	1		1													1
Quebec.....	Possession.....	44		22	16	2		1		1	2						44
	Selling.....	10		2	2			2		3	1						10
	Section 6.....	1		1													1
	Totals.....	55		25	18	2		3		4	3						55
Ontario.....	Possession.....	129		27	33	16	6	29	14	2	2						129
	Selling.....	4		2	1			1									4
	Totals.....	133		29	34	16	6	30	14	2	2						133
Manitoba.....	Possession.....	16		6	8			2									16
	Transporting.....	1							1								1
	Totals.....	17		6	8			2	1								17
Saskatchewan.....	Possession.....	2		1		1											2
Alberta.....	Possession.....	35		7	5	3		8	8	2	2						35
	Selling.....	1									1						1
	Totals.....	36		7	5	3		8	8	2	3						36
B.C.....	Possession.....	145		68	64	6		4	2		1						145
	Selling.....	3			1				1		1						3
	Totals.....	148		68	65	6		4	3		2						148
Yukon Terr.....	Possession.....	1		1													1

NOTE:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
 2. Concurrent convictions are not included in these totals.

COMPARISON
By PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1950

Province	Type of case	No. of cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession.....	2		2													2
New Brunswick.....	Nil.....																
Quebec.....	Possession.....	40		17	10	7		1	1	1	3						40
	Selling.....	4		2	1					1							4
	Section 6.....	1		1													1
	Transporting.....	1		1													1
	Totals.....	46		21	11	7		1	1	2	3						46
Ontario.....	Possession.....	78		21	19	9	1	16	9	2	1						78
	Selling.....	2			1		1										2
	Section 6.....	1	1														1
	Totals.....	81	1	21	20	9	2	16	9	2	1						81
Manitoba.....	Possession.....	15		3	3	1	2	2	1		3						15
Saskatchewan.....	Possession.....	1		1													1
Alberta.....	Possession.....	24		7	3			2	4	1	7						24
	Selling.....	3		1					2								3
	Section 10.....	1	1														1
	Growing Cannabis.....	1		1													1
	Totals.....	29	1	9	3			2	6	1	7						29
British Columbia.....	Possession.....	103*		54	58	4		23	16	3	2						160
	Selling.....	11						1	3	3	4						11
	Totals.....	174		54	58	4		24	19	6	6						171

* 3 Juveniles sentenced to indeterminate periods of detention.

Note.—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.

2. Concurrent convictions are not included in these totals.

COMPARISON

BY PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.

Calendar Year 1951

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Nil																
New Brunswick.....	Nil																
Quebec.....	Possession	42		10	12	5		4	2								42
	Selling	4		1	1			2									4
	Transporting	1		1													1
	Totals	47		21	13	5		6	2								47
Ontario.....	Possession	70		13	17	6	1	26	6			1					70
	Selling	1						1									1
	Transporting	1		1													1
	Totals	72		14	17	6	1	27	6			1					72
Manitoba.....	Possession	16		4	5		1	1	4		1						16
	Selling	1					1										1
	Transporting	1			1												1
	Totals	18		4	6		2	1	4		1						18
Saskatchewan.....	Possession	3			1	2											3
Alberta.....	Possession	13		5	1			4	3								13
	Selling	3								2		1					3
	Totals	16		5	1			4	3	2		1					16
B.C.....	Possession	190		58	63	20		32	10	4	2						190
	Selling	5							2		3						5
	Transporting	1									1						1
	Totals	196		58	63	20		32	12	4	6						196

Note.—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
 2. Concurrent convictions are not included in these totals.

COMPARISON
BY PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.
Calendar Year 1952

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Nil.....																
New Brunswick.....	Nil.....																
Quebec.....	Possession.....	24		12	6	3	1	1		2							24
	Selling.....	2		1													2
	Totals.....	26		13	6	3	1	1		2							26
Ontario.....	Possession.....	68		18	15	11	7	9	4	3	1						68
	Selling.....	5		2	2	1			2								5
	Totals.....	73		20	15	12	7	9	6	3	1						73
Manitoba.....	Possession.....	12		2	6	1	1	1				1	1				12
Saskatchewan.....	Possession.....	2		1					1								2
Alberta.....	Possession.....	13		7	1	2		1		1	1						13
B.C.....	Possession.....	262		73	96	15	2	48	20	4	2						*262
	Selling.....	23				1			8	1	12			2		1	* 23
	Totals.....	285		73	96	16	2	48	28	5	14			3			285

* Of the 2 Seven year sentences for possession, 1 received 10 strokes of the paddle and 1 received 5 strokes.

* Of the 12 Five year sentences for selling, 4 received 10 strokes of the paddle.
(All of the above were for offences involving juveniles)

Note:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
2. Concurrent convictions are not included in these totals.

COMPARISON
By PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.
Calendar Year 1953

Province	Type of case	No. of Cases	Fine only	6 mos.	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
New Brunswick.....	Nil.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Quebec.....	Possession.....	17	.....	8	1	1	.....	7	.....	.....	.....	.....	.....	.....	.....	.....	17
	Section 6.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	18	1	8	1	1	.....	7	.....	.....	.....	.....	.....	.....	.....	.....	18
Ontario.....	Possession.....	92	.....	23	27	7	1	20	10	3	.....	1	.....	.....	.....	.....	92
	Selling.....	4	.....	.....	.....	.....	.....	1	1	2	.....	.....	.....	.....	.....	.....	4
	Totals.....	96	.....	23	27	7	1	21	11	5	.....	1	.....	.....	.....	.....	96
Manitoba.....	Possession.....	12	.....	.....	3	.....	.....	7	2	.....	.....	.....	.....	.....	.....	.....	12
Saskatchewan.....	Possession.....	4	.....	3	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	4
	Section 10.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	5	1	3	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	5
Alberta.....	Possession.....	7	.....	2	.....	.....	.....	4	.....	.....	1	.....	.....	.....	.....	.....	7
	Transporting.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	8	.....	3	.....	.....	.....	4	.....	.....	1	.....	.....	.....	.....	.....	8
B.C.....	Possession.....	216	.....	59	89	16	.....	29	15	3	5	.....	.....	.....	.....	.....	216
	Selling.....	29	.....	.....	1	.....	.....	1	6	1	18*	.....	2	.....	.....	.....	29
	Totals.....	245	.....	59	90	16	.....	30	21	4	23	.....	2	.....	.....	.....	245

* One case also involved 5 strokes of the paddle.

Note:—1. Fines are not shown in this record, inasmuch as with the exception of offences under Section 10, a minimum fine of \$200.00 was mandatory under the provisions of the Act.
2. Concurrent convictions are not included in these totals.

COMPARISON

By PROVINCES, OF CONVICTIONS UNDER THE O.N.D. ACT SHOWING CONVICTIONS UNDER THE VARIOUS PENAL CLAUSES AND LENGTH OF SENTENCE AWARDED.
Calendar Year 1954

Province	Type of case	No. of Cases	Fine only	6 mos	Up to 1 yr.	Up to 18 mos.	Up to 2 yrs. less 1 day	2 yrs.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	7 yrs.	8 yrs.	9 yrs.	10 yrs.	Total by case
Nova Scotia.....	Possession.....	1	.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
New Brunswick.....	Nil.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Quebec.....	Possession.....	25	.....	9	4	3	.....	.....	4	3	2	.....	.....	.....	.....	.....	25
	Trafficking.....	9	.....	.....	1	.....	.....	1	2	2	3	.....	.....	.....	.....	.....	9
	Section 10.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	35	1	9	5	3	.....	1	6	5	5	.....	.....	.....	.....	.....	35
Ontario.....	Possession.....	67	.....	21	11	1	.....	17	8	5	2	2	.....	.....	.....	.....	67
	Trafficking.....	10	.....	.....	1	.....	.....	1	2	.....	5	.....	.....	.....	.....	1	10
	Possession for purposes of trafficking.....	3	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	1	.....	1	.....	3
	Totals.....	80	.....	21	12	1	.....	18	10	6	7	2	1	.....	1	1	80
Manitoba.....	Possession.....	7	.....	2	3	.....	.....	.....	.....	1	1	.....	.....	.....	.....	.....	7
Saskatchewan.....	Possession.....	4	.....	2	.....	.....	.....	2	.....	.....	.....	.....	.....	.....	.....	.....	4
Alberta.....	Possession.....	18	.....	5	2	.....	.....	7	1	3	.....	.....	.....	.....	.....	.....	18
	Trafficking.....	2	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	.....	.....	.....	.....	2
	Possession for purposes of trafficking.....	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	21	.....	5	2	.....	.....	7	1	4	1	.....	1	.....	.....	.....	21
B.C.....	Possession.....	176	.....	40	63	7	.....	28	20	4	11	.....	3*	.....	.....	.....	176
	Trafficking.....	6	.....	.....	.....	.....	.....	1	1	.....	1	.....	3*	.....	.....	.....	6
	Possession for purposes of trafficking.....	9	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1	.....	8	9
	Section 10.....	1	1	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	1
	Totals.....	192	1	40	63	7	.....	29	21	4	12	.....	6	1	.....	8	192

*Include Geo. Mallock case. He received a total of 14 years and fine of \$2,000 or 2 years additional under the O.N.D. Act, as also 7 years consecutive to above, a \$15,000 fine or 5 years additional under the C.C.C. for narcotic offences.
In June 1954, new penal clauses were included in amendments to the O.N.D. Act. They included penalties for trafficking and possession for the purposes of trafficking, with penalties increased to a maximum of 14 years.

APPENDIX U

SCIENTIFIC RESEARCH ON NARCOTICS AND ITS RELATION TO
TRAFFIC IN NARCOTIC DRUGS AND TO NARCOTIC LAW
ENFORCEMENT AND DRUG ADDICTION

Brief Submitted to
THE SPECIAL COMMITTEE OF THE SENATE OF CANADA
on the Traffic in Narcotic Drugs in Canada

by

The Food and Drug Directorate
(Organic Chemistry and Narcotic Section)

and

The Division of Narcotic Control
of the
Department of National Health and Welfare
Ottawa
Canada

Basic Principles

The drug addiction problem has three major components—the drugs, the addicted individual, and society. Each of these has to be considered in any serious study of the problem. In the brief the emphasis will be placed on the drugs. It is believed that an individual becomes addicted because of psychosomatic factors, which may be inherent in him, or may be caused or aggravated by social conditions. The causes of individual addictions are many and varied, and will require much more research and study before they are clearly understood. It is self-evident, however, that to become addicted the individual needs drugs, for one reason or another. The basis of our narcotic control law is simply stated as follows: “To prevent addiction to drugs one must control the supply of the drugs to society—no drugs—no addiction”. There is a wide divergence of views concerning the strictness with which this principle should be applied, in Canada and other countries; one group advocates a very rigid enforcement, while the others advocate a more flexible interpretation of the basic law. No matter which interpretation one favours, there is general agreement that controls in some form are necessary. Until society has reached a much higher stage of development it will continue to be necessary to enforce the controls on the supply of drugs, and to curtail as much as possible the illicit supply of drugs. It is the objective of this brief to outline some of the results of the application of scientific methods as an aid in the enforcement of narcotic drug law in curtailing illicit drug supplies, and to suggest plans for basic research on addiction in an endeavour to reach a more thorough understanding of its causes and amelioration.

The Illicit Traffic in Narcotic Drugs

Opium is still the major drug in the world traffic in drugs. The amount seized from the illicit traffic has not varied very much from year to year over the past quarter century. It amounts to about ten tons per year. This amount increased to about 100 tons in 1936 but dropped back to 10 tons the next year.

This sudden increase in the amount of seizures suggests that only about a tenth of the actual amount of opium in the illicit traffic is seized, the rest remaining undetected. For every ton of opium entering the illicit market this would represent on conversion about 4000 ounces of heroin.

Very little opium, as such, is seized in Canada. However in order to limit the use of opium to the legitimate manufacturing and medical and scientific needs in the world, it was realized that scientific methods for determining the source of raw opium were needed so that the international conventions and treaties controlling the material could be more effectively enforced. The primary purpose of the scientific research on opium has been to work out such methods for the detection of origin. No such methods existed when the work was begun in 1949. Until this time the circumstantial evidence surrounding a seizure was the basis for any suspicion of actual origin. Thus the itinerary of the ship, statements of the trafficker, colour and wrappings of the opium, and other such features although extremely valuable as evidence are not conclusive. It is necessary to have extremely strong methods and results in order to back up arguments at the international level. It is towards this objective that the opium research programme in about sixteen different countries around the world is directed.

Relation between Heroin and Opium in the Illicit Traffic

The question has often been asked—would it not be better to start with determining the origin of heroin rather than that of opium? Especially since heroin is the main drug in the illicit traffic in Canada.

There are two decisive reasons for starting with the origin of opium. First opium is a crude drug, containing many useful alkaloids, and showing all kinds of variations, some of which depend on soil, climate, methods of the farmers, and agricultural varieties grown in particular countries. Heroin, on the other hand, is a manufactured drug consisting when pure of one single compound, and if it does show any marks of origin, they are due to a particular factory and not to climate, soil and agricultural practices and plant varieties in the countries. Second, although heroin is the most important drug in the illicit traffic in Canada and the United States this is not true of all parts of the world, and although heroin is a more dangerous narcotic to be uncontrolled, opium is much more basic to the illicit traffic. Opium is not only used as an illicit drug in itself; illicit morphine is produced from opium, either opium produced illegally, or opium diverted from legal production; illicit heroin is then produced from illicit morphine. The most recent report of the Committee on Seizures of the Commission on Narcotic Drugs at United Nations (E/CN.-7/L.30, April 1955) noted that the illicit factories for the manufacture of heroin had recently been discovered in Japan, Mexico and Turkey, and that the volume of seizures of this drug and of illicit morphine base probably destined to be made into heroin was still considerable, and had not decreased very much. It was the unanimous opinion of the Commission that until something further could be done to control the supply of the raw material opium, the supplies of heroin for the illicit traffic would continue to increase.

Value of Determining the Origin of Opium Seizures to the Enforcement of Canadian Narcotic Law

The value of determining the origin of opiums seized in the illicit traffic in other parts of the world, is the basic one of cutting down on the source of supply of illicit opium and its derivative which eventually come into Canada. If illicit opium is mainly smuggled out of the producing countries, there may not be much awareness of the problem in the country of origin, since the traffickers who divert the opium or products illicitly are criminals in their own

countries. Origin determinations are intended to alert the government of producing countries to greater precautionary measures, and to alert the victim countries to their sources of danger. This is a function of the Commission on Narcotic Drugs of United Nations on which the governments of most of the producing countries, manufacturing countries, and the victim countries of narcotics traffic are represented. Certainly the whole field of origin determinations is a matter of international, and not primarily of national concern. It is of primary concern to Canada as a victim of the traffic in opium derivatives to see that the source of supply of illicit opium is cut down. The means for this rest in the determination of origin of opiums by scientific means at the international level through the Commission on Narcotic Drugs of United Nations. It is only by the mutual aid between countries that illicit traffic in opium will be eventually curtailed.

Progress of the International Programme of the Research on Chemical and Physical Methods of Determining the Origin of Illicit Opium

Administrative Progress

Preliminary scientific experimental work on opium methods was begun under the auspices of the United States Government by Charles C. Fulton prior to 1947. Actual research by the United Nations Secretariat chemists on methods of determining the origin of opium was begun February 1950. This research was authorized by two ECOSOC resolutions:

159 IIC (VII) of 3rd August 1948.

246 F (IX) of 6th July 1949.

The first resolution invited national governments to participate and asked them to provide samples of the types of opium produced in their countries. The second resolution authorized the Secretariat to carry out research, and set up an International Opium Distribution Centre at United Nations, and accepted the offer of the United States Government laboratory facilities.

Between 1950-1952 the Commission and Council confined themselves to a review of scientific progress, although in 1950 they authorized broadening the programme so that the Secretariat could study procedures for assaying opium for morphine and codeine, a problem in which WHO is vitally interested.

At the seventh session (1952) of the Commission it was resolved by a vote of 8 to 5 with no abstentions, that a beginning should be made in putting tests to practical use and that a United Nations Laboratory should be established. Additional samples of opium were also solicited. Council acted on only the latter part of this resolution, and then asked for a review of the methods and a report from a Committee of Chemical Experts (which was provided for in the same resolution from the Commission). The Commission reviewed the work of the Expert Committee (E/CN. 7/298) and at its ninth session (1954) (E/CN. 7/283) noted the further work done in developing the methods, delayed any application to seizures of opium, and recommended the review of the programme at its tenth session. That was the administrative progress up to the spring of this year (1955).

At its recent meeting on May 12th, 1955, after vigorous discussions held on May 3rd and 4th (See Provisional summary records E/CN.7/SR. 283, 284 and 285. UN Documents). The Commission succeeded in adopting a resolution advocating the practical application of scientific methods in determining the

origin of seized opium. The resolution was passed by a vote of 12 to 1 with two abstentions. To quote from a recent report of the Canadian Representative to the Narcotics Commission regarding this resolution:

"The resolution as finally adopted incorporated the four operative paragraphs of a Canadian Draft Resolution, with certain amendments from the United Kingdom, Greece, and Mexico into the United States proposal. The recommendations also effected a compromise between the extreme positions of the United States, which demanded a mandatory acceptance of laboratory findings by various countries, and India which requested a delay of application until another body of experts had reviewed the question of reliability of methods. It also stated the general opinion of the Commission with regard to such questions as the future of research in narcotics, and the division of responsibility for determining origins of seizures between the international laboratory and the laboratories of the national governments concerned." The eight points of the resolution are summarized as follows:

1. Reports required from governments under article 23 of the 1923 Convention for the limitation of the Manufacture of Narcotic Drugs sent to the Secretary-General of UN and to other parties to the Conventions should contain a determination of origin ascertained by physical and chemical methods on all important seizures of opium.

2. Governments making important seizures should send them to the Secretariat for scientific investigation of origin.

3. That the Secretary-General arrange such investigations of origin and report on them and their origin to the governments concerned in the seizure.

4. That the Secretary-General report to the Commission on Narcotic Drugs the number of samples of seized opium referred for chemical and physical analysis and the number of samples on which it was possible to determine the origin.

5. That a United Nations Laboratory be set up in the same place as the rest of the Narcotic Division, i.e. in Geneva.

6. That National Governments should consider setting up their own facilities for carrying out physical and chemical examination of samples seized in the illicit traffic to work in conjunction with the United Nations Narcotics Laboratory.

7. That the methods used for determining the origins be based on authenticated samples and that the methods used on seizures be specified in any reports to the Secretary-General.

8. That the experts who have co-operated in the experiments report on the degree of certainty with which the origins can be determined at present, in the various cases.

Importance of the Application of Scientific Methods in Analysis of Opium

The above resolution for the first time sets up the essential administrative machinery for the application and use of the methods of opium analysis in the curtailing of illicit opium in the traffic in drugs. It may mark the beginning of the use of scientific methods in the enforcement of the international law in control of narcotic drugs, providing it is accepted by the Economic and Social Council and the General Assembly of the United Nations, and providing the National Governments make the proper use of the means at their disposal for curtailing the traffic in opium.

Specific Canadian Contribution to the International Program of Scientific Research on Chemical Methods of Determining Origin of Opium

The Canadian Government in 1948 after discussion in the Department of National Health and Welfare between Dr. G. D. W. Cameron (D. M. H.), Dr. C. A. Morrell, Dr. L. I. Pugsley (Directors of the Food and Drug Laboratories) and Mr. K. C. Hossick (Chief of the Narcotic Control Division) offered to participate in the United Nations International Program of research in opium. These deliberations coincided with the establishment by these men of a Federal Narcotics Laboratory, as a part of the Food and Drug Laboratories of the Department of National Health and Welfare.

Opium research was begun in 1949 under the direction of Dr. Charles G. Farmilo, head of the Organic Chemistry and Narcotic Section at the Food and Drug Laboratories. Two major lines of investigation of chemical and physical methods of determining origin of opium have been followed since that time by Dr. Farmilo and Mrs. Patricia Oestreicher and their colleagues, Mr. J. C. Bartlet (Food Chemistry Section) and Dr. Percy McKinley (Physiology and Hormones Section). First, the methods developed by the United Nations chemists have been tried, tested and applied in a general scheme of determinations. Second, new methods such as the spectrochemical ash method and recently the electrophoretic method have been developed and applied in this laboratory to opium analysis. A general scheme of opium origin analysis has been worked out, and incorporated into it as a semi-automatic mechanical method of sorting data, which enables more objective decisions, regarding the origin of specific seizures, to be made.

This complex scheme of methods of discriminating origins has now been applied to fifty-eight samples of unknowns. That is, these samples were supplied to the Organic Chemistry and Narcotic Section and distinguished merely by a number, their real origins were known only to the chemist at United Nations. The score on these trials of methods is as follows:

SCORE OF TRIALS ON DETERMINATION OF ORIGIN OF
OPIUM UNKNOWNs

No. of unknown samples submitted	Correct country	Degree of Identification			Totals
		Generally (region only)	Not definite	Incorrect as to country	
Samples of authentic origin	34	3	0	1	38
New types not previously studied	5	0	0	0	5
Seizures—origin determined by Secretariat	5	1	1	0	7
Total number	44	4	1	1	50

Eight special actual seizures from the illicit traffic entering the United States were identified for the United States Government by the scientific methods. The results on these eight seizures were as follows: identified as to country of origin—7; new type discriminated—1.

One of the samples submitted by the United States Government is particularly interesting because it shows how difficult it is to specify origin by the circumstances attendant on the seizure. The opium sample was seized from

a ship whose itinerary included the following ports: Charleston, S.C.; Panama Canal; Los Angeles; San Francisco; Manila, P.I.; Yokohama; Hong Kong; Djakarta; Siam; Saigon, Indochina; Singapore; Belawan; Penang, F.M.S.; Ceylon; Allopey, India; Cochin, India; Suez; Halifax, N.S.; Boston, New York. The seizure was made by Customs authorities in New York, but it is of interest to us that the opium was on board when the ship touched Canada. There was no doubt of the origin of the sample—after the chemical and physical examination of the seizure had been made; the sample was definitely of Indian origin. However, by ordinary means it could have come from China, Indochina, Indonesia, the Near East, etc. The purpose of examining these seizures was to demonstrate the validity and usefulness of the origin determinations in making such distinctions.

A further fifteen opium unknowns are being examined at present in the Federal Narcotics Laboratory.

*Effect of the Canadian Scientific Work on the United Nations
Narcotics Commission*

The presentation of the results of the work on opium of the Canadian scientists at the ninth and tenth sessions of the Commission on Narcotic Drugs in 1954 and 1955 by Mr. K. C. Hossick (Canadian Representative to the Commission) and Dr. C. G. Farmilo (Technical Adviser to the Canadian Representative on the Commission) has gone a long way in convincing the representatives on the Commission from other countries of the reliability and usefulness of scientific methods in aiding in the international enforcement of the control laws and conventions. The Canadian scientific results were a major factor in laying the basis for the resolution described above. This resolution, on the basis of the Canadian contributions both scientifically and administratively, suggests certain machinery for the determination and reporting of scientific findings which had been lacking in the international narcotic administrative structure until this year. This is an important point since the Commission now has definite means and authority to hear and act upon the firm basis of scientifically determined facts as to the origin of illicit traffic.

This resolution will eventually have the effect of tightening the control of opium production and preventing the supply to illicit traffic.

The second important point emerging from the Canadian work has been that national governments have been urged to set up laboratories similar to the Federal Narcotics Laboratory, wherein determinations of origins by chemical means can be made in the countries most affected by the opium traffic. In this regard it was pointed out by the Canadian Representative that the Canadian Authorities are most anxious to assist governments which did not have such facilities at present, by carrying out actual analyses in Canada. This service would be provided either as a check on analyses made at the United Nations Narcotics Laboratory, or as an initial finding for any government requesting the service, on the understanding that the country of origin is notified as to the findings in addition to the country submitting the seizure.

As a further aid to those countries wishing to set up laboratories of their own for origin determinations or research, the Canadian Representative offered the services of the Food and Drug Laboratories as a training ground for scientists in other parts of the world in the use of our new methods. This would help in providing the necessary number of experts in the most crucial parts of the world near the source of the illicit opium.

The outcome of this offer of technical assistance on our part has been that Egypt and Iran and the United Kingdom have suggested that scientists from their countries be sent to Canada to study and do research on opium. The Indian Representative, on a recent visit to the Federal Narcotics Laboratory, also expressed keen interest in this plan for "technical aid in narcotic analysis.

Since the termination of the meeting of the Commission, preliminary steps to implement this plan for technical aid to study opium have been made in Canada and abroad. It may be possible to gain the necessary financial support for the students under the United Nations Technical Assistance Programme for countries like Egypt and Iran, and under the Colombo plan for countries in South and Southeast Asia, i.e. India, Malaya Federated States, Burma and Indochina. It is very important that these countries be brought into the plan, since a large part of illicit opium from which heroin is made may be coming from this part of the world.

Basic Scientific Research on the Problem of Drug Addiction

The second objective of this brief is to emphasize the need for basic research to be done in Canada on the problems related to the causes of addiction to drugs in humans. One of the important problems to be studied is the relation between the chemical structure and the biological activity of narcotic drugs. The determination of addiction liability of new drugs is essential before a narcotic can be placed under control. No such determination can be made in Canada. At present, methods for this purpose involve trials on human subjects, and the study of this kind helps the elucidation of the causes of addiction in humans, and may also provide a knowledge which could aid any future treatment of narcotic addiction in Canada.

Presently, physical and chemical methods of determining the structure of drugs is under investigation by Dr. Charles Farmilo and Dr. Leo Levi in the Federal Narcotics Laboratory. One of the objectives of this work is to try to elucidate the structures in such a way as to be of assistance to the interpretation of biological action. If a hospital for the treatment of addicts is to be contemplated, it should contain a Drug Addiction Research Laboratory. It would be valuable to man this hospital laboratory with scientists with training in Organic and Physical Chemistry, Crystallography, Physiological Chemistry and Medicine in order to solve the problems related to the causes of drug addiction.

To a certain extent such a plan is underway in the U.S.A. where a Drug Addiction Committee is part of their National Research Council setup. This committee is bringing together experts in several fields from universities, government and industry.

Conclusions

Progress in the field of scientific research in narcotics in Canada has been made. The chemical and physical determination of origins of illicit opium has been brought to the point of application by international and national government laboratories, largely on the basis of collaborative work of the Division of Narcotic Control and scientists at the Food and Drug Laboratories of the Department of National Health and Welfare. Further research on narcotic drugs in Canada and in other countries can be facilitated by assisting scientists to come to Canada to study the methods of opium analysis. The Food and Drug Laboratories will welcome scientists from other countries who wish to work in its new building.

Work has been carried on in the same Federal Narcotics Laboratory on the chemical structure of narcotic drugs, with the view to aiding eventual solution of the problem of relationship between structure and activity of

narcotic drugs. This problem is basic, and its solution will lead to a better understanding and control of drug addiction. There is a need for a research laboratory to study such basic problems in drug addiction. The complexity of the drug addiction problem and its components—the drugs, the addicts' personality and social causes—must be studied from the point of view of fundamental research before even a partial solution can be expected.

APPENDIX V

Statement of Commissioner Harry J. Anslinger,
Bureau of Narcotics, Treasury Department,

Before the Senate Judiciary Sub-Committee on Narcotics
June 2, 1955

This Committee has the distinction of being charged with the responsibility to make a thorough review of the illicit narcotics traffic and to recommend new laws that will strengthen our attack on the narcotics problem.

The findings of this Committee will be eagerly anticipated not only by all of us who are concerned with the administration and enforcement of the narcotic laws but by every citizen of the United States. I am confident that the investigation of this Committee will be conducted with the utmost thoroughness and competence, and that its findings will serve as an invaluable guidepost in the interpretation and simplification of our Federal narcotic laws.

Your Committee will be interested to know that the incidence of drug addiction in Canada closely approximates that in the United States and that a special committee of the Canadian Senate has been engaged for several months in making a study similar to the one you are conducting. I venture the suggestion that your Committee exchange records with the Canadian Senate Committee particularly because the narcotic traffic in both countries is similar and trafficking is interlocked because of smuggling into both countries from Europe and the Far East.

DRUG ADDICTION

Drugs used:

For many years morphine, heroin, smoking opium, and cocaine were the principal drugs used illicitly in the United States. In recent years marihuana smoking has become an increasing problem.

Since about 1950 it has been evident to narcotic agents and local police authorities that most addicts in the United States have preferred heroin. Traffickers can buy small quantities of pure heroin, and by adulterating it, make enormous profits from sales to eager addicts. Because of its addicting qualities, because its therapeutic value is no greater than that of morphine, and also because of its high toxicity, heroin may not be legally imported, manufactured, or sold in the United States. It has been outlawed in all but five countries.

Heroin is injected by needle. Marihuana is smoked in the form of cigarettes. There is some opium smoking among Chinese and some morphine is used by addicts who rob drug stores, and also forge doctors' prescriptions.

In recent years synthetic drugs have become an increasing problem in this as well as in other countries. Certain professional and sub-professional groups constitute those addicted to synthetic drugs, whereas people in the lower social levels have been the greatest offenders in addiction to natural narcotic drugs.

Extent:

Before the passage of national control legislation there was one addict in every 400 persons in the United States. By World War I this incidence had been reduced to about one in every 1,500 persons, and by World War II the incidence was found to be roughly one in 10,000 rejected for military service because of addiction. At this time the narcotic traffic in the United States was probably at the lowest ebb since the enactment of Federal legislation to control narcotics. Following World War II and the resumption of shipping there was an influx of heroin from the Middle East and European countries. Beginning in 1950, heroin from an uncontrolled source, Communist China, began to reach the United States in volume. This traffic still continues. Heroin smuggling from Lebanon is also a serious problem.

The total number of addicts in the United States today is estimated at between 50,000 and 60,000, or an incidence of about 1 in 3,000 of the population. An interim report on the survey of drug addiction begun by the Bureau of Narcotics in January 1953 shows 28,514 addicts counted to date. It is believed that this count, consolidated monthly from reports received from Federal, State, and local authorities throughout the United States, will approach the above estimate in 2 to 3 years.

Among the addicts reported in the survey, 77.83 percent used heroin, 9.81 percent used morphine, 1.47 percent used opium, 6.3 percent used synthetic drugs, and 4.52 percent and 0.07 percent were reported as using marihuana and cocaine respectively.

Males accounted for 79.01 percent of the total; age groups of both sexes were as follows:

Years	Percent
Under 21	13.1
21 to 30	50.3
31 to 40	19.4
Over 40	17.2

A further study of the group under 21 years of age revealed that 87.61 percent of this group were 18 years old or over.

Reports relating to the United States Public Health Service Hospital at Lexington show that the majority of persons addicted to opiates come from cities of one million or more population.

Addiction statistics maintained by the Bureau of Narcotics show the greatest concentration of addicts in the areas of New York City, Chicago, and Los Angeles, with these areas showing 7,937, 6,975, and 1,896, respectively for the 2-year period 1953-54. The strength of the Bureau of Narcotics is concentrated in these areas of the most illicit activity, and here is also found a pooling of equipment with other agencies and the police departments.

Drug addiction among adolescents took on major proportions after World War II, and reached its peak about 1951. Since then it has shown signs of abating except in several areas.

Drug addiction among youth is usually a part of the overall juvenile delinquency problem, although some adolescents try drugs for the thrill they hope to get out of them, and despite all warnings of the dire consequences of indulging in this deadly habit, they believe they can try them and then give them up, only to discover too late that their curiosity was the vehicle of their utter ruin. Youthful addicts, if given treatment during the early stages of their addiction, represent the most hopeful cases for complete cure of the drug habit.

Treatment:

The length of time required to bring about drug addiction may be only a few weeks, if the drug is taken regularly and frequently. It is usually first taken in small quantities and at infrequent intervals, but as the craving begins to become insatiable the quantity and frequency must be increased so that the addict will experience the feeling of euphoria which he felt in the early stages of his addiction because by this time his body has built up a tolerance to the drug. This may mean that he will now take a number of capsules, for intravenous injections, daily.

The physical effects of drug addiction are plainly visible in most addicts, because with continued addiction the victim is likely to neglect to eat enough nutritious food, for he no longer cares about anything except keeping himself supplied with drugs. Abstinence from the use of drugs, either during the course of treatment in a Federal narcotic hospital or while serving a prison sentence, ordinarily restores the addict to normal physical health, even though his psychological dependence on the drug may not have been changed. If he returns to using drugs, his physical condition again will undoubtedly deteriorate, together with his moral structure.

The maintenance of addiction is so expensive that most addicts cannot possibly maintain their supply of drugs without resort to vice. When his daily intake is comparatively small the addict may cover up his diversion of cash on hand for this purpose, but when the evil has completely mastered its victim, he must have large amounts of money, because he is required to pay cash before the peddler will let him have the drug he craves. From shoplifting and petty thievery, the addict quickly graduates to major crimes.

Many addicts have a history of social maladjustment, and are likely to be well schooled in crime before they turn to drug addiction. Many of them have been the victims of parental neglect and broken homes.

Drug addiction could not exist without the availability of drugs. Neither could it exist without the desire of the individual for these drugs.

A workable solution of the drug problem involves close coordination of the most strenuous efforts of narcotic enforcement agencies and medical authorities. Penal institutions make us safe from criminal drug addicts and drug peddlers by keeping these undesirable people off the streets and out of further criminal activity. The Federal hospitals, and State and private institutions specially equipped to treat drug addiction can withdraw physical dependence on drugs, and by extensive psychological reconditioning, help addicts make the adjustment necessary to resume their normal place in life. Many addicts lack the moral stamina to abstain from using drugs after they are apparently cured. Some return several times for the same course of treatment. Medical authorities in charge of these rehabilitation programs believe that even though an addict relapses several times, there is some hope that he may eventually respond to treatment and never return to the use of drugs. Regular medical examinations and conferences at regular intervals following addiction withdrawal treatment are likely to be helpful in preventing recidivism.

Rehabilitation facilities are available and are being used at the United States Public Health Service Hospitals in Lexington and Fort Worth, as well as at State and private institutions. Riverside Hospital, North Brothers Island, New York City, rehabilitates youthful drug addicts in the State of New York.

Some progress has also been made in rehabilitation in Chicago and Detroit. After-care is probably one of the most promising phases of rehabilitation.

The American Medical Association, the National Research Council, the United Nations Commission on Narcotic Drugs, and other authorities on the subject of addiction have stated that drug addiction cannot be cured by ambulatory means.

LEGISLATION

The first regulatory Federal narcotic measure enacted in the United States was the Act of February 9, 1909, which prohibited the importation and use of opium for other than medicinal purposes. This was followed December 17, 1914, by the Harrison Narcotic Law, which was a taxing measure designed to have the effect of regulating particularly the domestic trade and distribution of narcotic drugs.

The Act of February 9, 1909, was consolidated and amplified and given the title of the Narcotic Drugs Import and Export Act on May 26, 1922. It was further amended June 7, 1924, to limit generally the importation and exportation of narcotic drugs, to prohibit the importation of opium for the manufacture of heroin, and, as a practicable measure, to outlaw heroin in the United States.

Although the Harrison Narcotic Law was enacted in the form of a revenue measure, it also served to give effect to obligations incurred under the 1912 International Opium Convention. The Opium Poppy Control Act of December 11, 1942, was also based on treaty obligations and as a practicable measure prohibited the growing of the opium poppy in the United States, since in no case has a license been issued for this purpose.

The Marihuana Tax Act of August 2, 1937, limited the use of marihuana to legitimate medical needs. This in effect prohibited the use of marihuana because it has since been removed from the United States Pharmacopœia, as it serves no useful medical purpose.

Public Law 255, 82d Congress, 1st Session, known as the Boggs Act, amended the penalty provisions of the Harrison Narcotic Law, the Narcotic Drugs Import and Export Act, and the Marihuana Tax Act to provide minimum penalties of two, five, and ten years for first, second, and third time offenders, respectively. Upon conviction for a second or subsequent offense, the imposition or execution of sentence shall not be suspended and probation shall not be granted.

By a recent amendment to the Internal Revenue Narcotic laws (Public Law 729, 83rd Congress, approved August 31, 1954) authority was granted whereby registered retail dealers (druggists), subject to stated conditions, might fill oral prescriptions for certain narcotic drugs and compounds of narcotic drugs which were found and by regulation designated to possess relatively little or no addiction liability.

CONTROL OF LEGITIMATE TRADE

The Bureau of Narcotics issues permits to import crude narcotic drugs and to export drugs and preparations manufactured therefrom under the laws and regulations, and determines the quantities of narcotic drugs to be manufactured in the United States for medical purposes. It exercises control over the legitimate production and distribution of narcotic drugs through the approximately 200,000 registrants; namely, manufacturers, wholesalers, physicians, and pharmacists.

A limit is imposed on the amount of drugs manufactured in order to comply with the requirements regarding estimates of the 1931 Convention for the Limitation of the Manufacture of Narcotic Drugs. Also in compliance with this convention, manufacturers are required to make quarterly returns of raw materials and drugs received into the factory, of drugs produced, of raw materials and products disposed of, and of the quantities remaining in stock.

Wholesalers are required to make monthly returns of all transactions. Physicians and retail pharmacists are required to keep detailed records of drug transactions and to make them available to persons authorized to inspect them.

FEDERAL ENFORCEMENT

The enforcement of the above laws and amendments thereto and all other Federal narcotic laws has from the beginning been the responsibility of the Treasury Department, and the laws relating to the enforcement and administration of the internal distribution of narcotic drugs and marihuana have been held constitutional because they are taxing measures.

The Act of June 14, 1930, created in the Treasury Department a bureau known as the Bureau of Narcotics, which is charged with the investigation, detection, and prevention of violations of the Federal narcotic and marihuana laws and of the Opium Poppy Control Act mentioned above. In addition, the Bureau of Narcotics supervises the administration of those sections of the Internal Revenue Code relating to narcotic drugs and marihuana, the Opium Poppy Control Act, and related statutes including the permissive features of the Narcotic Drugs Import and Export Act.

In addition to working closely with the Bureau of Customs, which has sole responsibility to prevent smuggling, the Bureau of Narcotics concentrates its efforts on interstate violators and on large wholesale traffickers, both interstate and intrastate, as the most effective utilization of limited manpower in the fight against the vicious underworld traffic in narcotics. There is also extensive liaison and cooperation with State and local authorities in eliminating the small retail peddlers of narcotics.

Through cooperation with foreign governments, the Bureau of Narcotics has assigned agents to work with enforcement authorities of those governments to develop evidence against international narcotic traffickers, to eliminate the source of supply of the contraband at the point of origin or transit before the narcotics reach the United States. The Bureau has found that engaging the international traffickers first hand at the source more than warrants the small number of agents that can be made available for this important duty. Our main task abroad is to destroy clandestine laboratories for the manufacture of heroin destined for the United States.

Over a 25-year period the enforcement of Federal narcotic laws has been accomplished with an average force of 227 agents and an average budget of \$1,623,892. This limited force, using every available facility, has had to curtail investigations because of lack of funds to purchase evidence and extend undercover operations into the intricate facets of the traffic, both in the United States and foreign countries of source and transit to the United States.

Although Congress has authorized 275 agents for the Bureau of Narcotics, the present budget of \$2,770,000 limits the number of agents to 250, which is a field force about the size of the average police force of a city of 200,000 to 300,000 population. These agents average 57 hours of work per week, and are responsible for about 3,000 convictions annually, which is approximately 300 per cent greater production than most other enforcement agencies.

The scope of productive investigations by the Bureau of Narcotics is emphasized by the fact that for an 8-year period, 1947-54, an average of 11.8 per cent of the total Federal prison population in the United States were persons

convicted of violations of the Federal narcotic and marihuana laws, whereas Federal narcotic agents account for a very small percentage of Federal enforcement officials. This average progressed from 9 per cent in 1947 to 15.7 per cent in 1954.

Comparative seizures of narcotics

Name of drug	Average seizures for 1930, 1931, and 1932	Average seizures for 1951, 1952, and 1953
	Ounces	Ounces
Raw opium	24,613	1,691
Smoking opium	8,090	1,908
Morphine	13,030	59
Heroin	5,829	1,867
Cocaine	346	45

These figures not only illustrate the reduced availability of the drugs in the illicit traffic through the enforcement work of the Bureau of Narcotics in the United States and abroad in cooperation with authorities of other governments, but also accentuate the changed picture of enforcement in that heroin has supplanted both opium and morphine as the principal drug in the illicit traffic. Although this change is also reflected in other countries, it is particularly true in the United States where the heroin, a compact, easily concealed, high-tension, dangerous narcotic preferred by addicts, commands a dollar value far in excess of gold, which has made the investigations of the Bureau of Narcotics leading to the sources of supply not only more complex and extended but also much more costly.

New York City is the center of much of the illicit traffic in heroin, as it is smuggled through the port despite the constant vigilance of Customs officers. Most of the heroin is cut to a small fraction of its original purity, and large quantities of it in highly adulterated form reach inland cities, where they are sold by local peddlers directly to addicts, at exorbitant prices.

During 1954 the principal sources of raw opium were Mexico, India, Pakistan, and Iran, and the total quantity seized throughout the United States was 781 ounces, compared with 690 ounces seized in 1953. The principal sources of prepared opium were Mexico, Kuwait, and Hong Kong, and the total quantity seized was 3,385 ounces, compared with 1,805 ounces seized in 1953. The principal sources of heroin were Communist China, Lebanon, France, Singapore, Thailand, and Mexico, and the total quantity seized was 1,787 ounces, compared with 2,360 ounces seized in 1953.

STATE ENFORCEMENT

State and local enforcement officers have been extremely cooperative in assisting the Federal officers in the task of investigating and bringing to justice dealers in illicit narcotics. The experiences of many of these local and State officers should prove valuable to your committee in studying the situation throughout the country.

At present all except five States have a Uniform Narcotic Law and all except three States have adequate narcotic legislation for effective enforcement. The number of State enforcement personnel is as follows:

<i>State</i>	<i>Number</i>
California	35
Connecticut	2
Florida	6
Kentucky	5
Michigan	1
New Jersey	6
New York	6
North Carolina	2
Oklahoma	2
Pennsylvania	13
Rhode Island	2
Tennessee	1
Texas	4

LOCAL ENFORCEMENT

About 1950, the municipal police entered the field of narcotic work, and soon these local police were obtaining evidence to substantiate charges of illegal sale and possession of drugs, leaving the Bureau of Narcotics free to devote its time exclusively to the major problem of the wholesale trafficker.

In this stupendous task of bringing to justice the extremely cunning drug addicts and peddlers (many of whom are also addicts), local narcotic squads, working as part of their regular police departments, are doing a great deal of commendable work in tracking down illicit narcotic violators.

There are 24 cities throughout the United States in which the police maintain a Narcotic Division or Narcotic Squad. Foremost among these are: New York City with 200; Chicago with 94; and Los Angeles with 77.

There are 35 other cities with one or two police officers assigned to narcotic enforcement activities, bringing the total non-Federal narcotic enforcement personnel in the United States to 610.

The combined force of Federal, State, and local authorities accounted for 23,365 narcotic arrests in 1954. Some 60 per cent of these arrests were in five cities, as follows: California 7,407; Illinois 2,046; New York 4,696; Michigan 1,924; and Texas 1,414. The concentration of narcotic traffickers in larger urban areas was pointed up by the fact that 89.9 per cent of the total narcotic arrests reported were in 44 representative cities located throughout the United States.

PENALTIES

A severe blow has been dealt to the illicit drug traffic by the imposition of heavier penalties in the form of large fines and long prison sentences for drug peddlers and smugglers. In many parts of the country the Federal and State courts are now imposing these heavier penalties. Wherever this has been done consistently the drug traffic has noticeably decreased, as in New Jersey, Florida, Maryland, Virginia, the Northwest, and other States.

Another effective means of controlling this traffic is in effect in New Jersey, where a recent law designates a drug addict as a disorderly person, punishable by a fine of \$1,000 or 1 year in prison, or both. This law might well be adopted by all States. Compulsory commitment of drug addicts to an institution for adequate treatment should be carried out by all States and communities.

INTERNATIONAL COOPERATION

International narcotic controls have been accomplished over a 42-year period of trial and error. The first Assembly of the United Nations created the Commission on Narcotic Drugs. It is engaged in a great humanitarian effort to suppress the abuse of dangerous drugs and thereby reduce human misery. Its predecessor, the Opium Advisory Committee, was the only League of Nations organization which continued to function throughout the world during hostilities. The Narcotic Commission acts by making use, on the one hand, of the effective means made available by the several narcotic conventions and, on the other hand, of public opinion. The United Nations Narcotic Protocols are among the most important technical achievements standing to the credit of the United Nations.

Three other international bodies are engaged in this work. The trade in narcotics is watched over by the Permanent Central Opium Board, which meets semi-annually in Geneva. Another international organ, the Supervisory Body, meets semi-annually to review the estimates of all governments for medical needs. Nations have surrendered sovereign rights in this field to the extent that if they fail to furnish such estimates they will be bound by the estimates set up by the Supervisory Body. The Committee on Drug Addiction of the World Health Organization sits annually to review the field of newly discovered drugs to determine which shall be placed under international control.

The concerted international program in the field of narcotic drugs is directed toward the following objectives:

- (a) Improving the national and international legislation and administrative machinery in the field of narcotics;
- (b) Regulating national and international trade in narcotics;
- (c) Coordinating the efforts for treatment and eradication of drug addiction.

The basic instruments for attaining the above-mentioned objectives are six international treaties transferred from the League of Nations and three concluded under the auspices of the United Nations. A consolidated and improved convention is being prepared to replace all the instruments at present in force.

International control cut the manufacture of narcotic drugs almost in half. It reduced the world legitimate consumption of heroin from 2,650 kilograms to 266 kilograms. The 1948 Protocol giving international control to the new dangerous synthetic drugs throughout the world saved the United States from a flood of these dangerous drugs from European factories. When the 1953 Protocol for worldwide limitation of opium production comes into force, the tremendous overproduction of opium and the narcotics derived from it abroad—which feeds our illicit smuggling traffic—should be curtailed.

CONCLUSION

Despite the substantial progress which has been made in the field of narcotic drug control, there is abundant evidence that drug addiction remains a serious problem. Strong laws, good enforcement, stiff sentences, and a compulsory hospitalization program are the necessary foundations upon which any successful program must be predicated. These will go a long way toward suppressing the abuse of narcotic drugs. The greatest reason for an increase in drug addiction has been the failure on the part of the legislators and other officials to observe these important fundamentals.

Statement of Commissioner Harry J. Anslinger,
Bureau of Narcotics, Treasury Department,

to

Senator Daniel's Subcommittee

of the

Senate Judiciary Committee

June 2, 1955

As requested by your Committee I attach hereto reports showing the concentration of the narcotic traffic in the United States. These reports cover addiction as well as arrests and convictions for narcotic offences.

ADDICTION

The Tables showing the number and distribution of addicts are based upon actual names and records reported to the Bureau of Narcotics by local, state and federal authorities since January 1, 1953.

It is significant to note this count of addicts has been and is now progressing at the rate of 1,000 per month with a total of 28,514 counted for the 28 months ending April 30, 1955.

This does not mean we have the names of all addicts in the nation, but we are continuously compiling this information and the rate of count has remained fairly constant at 1,000 per month since the present survey began.

A survey conducted under the auspices of the United States Public Health Service showed that every addict questioned was known to local or federal authorities which shows our survey is fairly accurate. It is the experience of narcotic authorities that every addict comes to the attention of authorities within a period of approximately two years.

It is estimated the total count will be reached within a five year period, and that the total will approximate 60,000.

As requested, the concentration of addicts thus far reported is as follows by States:

New York	9,458	Territory of	Arizona	128	
Illinois	7,172	Hawaii	268	North Carolina	128
California	2,350	Florida	249	Minnesota	123
Michigan	1,229	Maryland	247	Colorado	116
District of		Washington	200	Virginia	112
Columbia	887	Georgia	197	Alabama	111
Ohio	785	Massachusetts	186	Connecticut	110
Texas	771	Indiana	176	Oklahoma	108
Missouri	535	Wisconsin	165	South Carolina	107
New Jersey	443	Tennessee	136	Louisiana	106
Pennsylvania	323	Mississippi	134		

Addicts reported in the above 28 States, the District of Columbia and the Territory of Hawaii account for 27,060 or 95 per cent of the total reported thus far.

ARRESTS AND CONVICTIONS

The Tables showing arrests and convictions are based upon reports made to the Bureau of Narcotics from actual records maintained by local, state and federal authorities.

Based upon these reports, the narcotic traffic in the United States is concentrated principally in the following States:

NARCOTIC AND MARIHUANA ARRESTS
1953-54

California	16,532	District of	Connecticut	182	
New York	8,785	Columbia	546	Arizona	146
Illinois	6,667	Missouri	510	Oregon	138
Michigan	3,618	Indiana	398	Kentucky	129
Pennsylvania ...	3,335	Wisconsin	311	Colorado	127
Texas	2,854	Oklahoma	309	New Mexico	120
Ohio	1,168	Maryland	258	Minnesota	97
New Jersey	1,077	Florida	233	Georgia	94
Louisiana	772	Territory of	Tennessee	85	
Massachusetts ...	687	Hawaii	217	Nevada	75
		Washington	197	Alabama	72

Arrests reported in the above 28 States, the District of Columbia and the Territory of Hawaii account for 49,739 arrests or 98 per cent of the total reported for the two year period.

NARCOTICS AND MARIHUANA CONVICTIONS
1953-54

New York.....	6,838	Wisconsin	232	Oregon	108
California	6,646	Louisiana	204	Colorado	93
Illinois	3,373	Maryland	201	Territory of	
Texas	1,465	Washington	188	Hawaii	85
Pennsylvania	1,274	Florida	177	New Mexico	85
Ohio	929	Oklahoma	152	Georgia	71
New Jersey	897	Connecticut	146	Tennessee	69
Massachusetts ...	545	Missouri	141	Utah	60
Michigan	448	Indiana	115	Alabama	55
District of		Arizona	109	Minnesota	55
Columbia	302	Kentucky	108		

Convictions reported in the above 28 States, the District of Columbia and the Territory of Hawaii account for 25,171 convictions or 97 per cent of the total reported for the two year period.

Based upon the same reports the concentration of the narcotic traffic by cities is as follows:

NARCOTIC AND MARIHUANA ARRESTS

1953-54

Los Angeles, California.....	12,461	Oklahoma City, Oklahoma	235
New York City, N.Y.....	8,437	Honolulu, T. H.	211
Chicago, Illinois	6,643	Fresno, California	194
Detroit, Michigan	3,565	Cincinnati, Ohio	177
Philadelphia, Pa.	2,779	Dayton, Ohio	172
San Francisco, California	901	Buffalo, New York	163
New Orleans, Louisiana	713	Seattle, Washington	144
Newark, New Jersey	699	Indianapolis, Indiana	126
San Diego, California	669	Portland, Oregon	126
Cleveland, Ohio	666	Atlantic City, New Jersey	113
Houston, Texas	647	Miami, Florida	111
Boston, Massachusetts	614	Denver, Colorado	109
District of Columbia	546	Albuquerque, New Mexico	97
Pittsburgh, Pennsylvania	524	Phoenix, Arizona	86
Sacramento-Stockton, Cal.	425	Hartford, Connecticut	82
Milwaukee, Wisconsin	306	Fort Worth, Texas	69
Oakland, California	300	Minneapolis, Minnesota	63
San Antonio, Texas	292	Atlanta, Georgia	61
Baltimore, Maryland	252	Omaha, Nebraska	55
St. Louis, Missouri	250	Louisville, Kentucky	53
Dallas, Texas	248	Salt Lake City, Utah	53
Kansas City, Missouri	248	Las Vegas, Nevada	50

Arrests reported in the above 45 cities total 44,735 or 88 per cent of the total reported, 50,595, for the two year period.

NARCOTIC AND MARIHUANA CONVICTIONS

1953-54

New York City, New York....	6,565	Fresno, California	131
Los Angeles, California	4,406	Dayton, Ohio	115
Chicago, Illinois	3,350	Atlantic City, New Jersey.....	106
Philadelphia, Pa.	963	Oklahoma City, Oklahoma	106
Cleveland, Ohio	550	Portland, Oregon	95
Newark, New Jersey.....	532	Denver, Colorado	89
San Francisco, California	517	Dallas, Texas	85
Boston, Massachusetts	477	Honolulu, T.H.	83
Detroit, Michigan	430	Miami, Florida	81
San Diego, California	396	Kansas City, Missouri	80
District of Columbia	302	Albuquerque, New Mexico.....	73
Pittsburgh, Pennsylvania	282	Hartford, Connecticut	61
Milwaukee, Wisconsin	227	St. Louis, Missouri	59
San Antonio, Texas	226	Louisville, Kentucky	55
Baltimore, Maryland	201	Phoenix, Arizona	52
Houston, Texas	179	Fort Worth, Texas	51
New Orleans, Louisiana	170	Salt Lake City, Utah	51
Sacramento-Stockton, Cal.	158	Atlanta, Georgia	44
Cincinnati, Ohio	152	Jacksonville, Florida	44
Buffalo, New York	142	Minneapolis, Minnesota	42
Seattle, Washington	139	Toledo, Ohio	39
Oakland, California	132	Memphis, Tennessee	38

Convictions reported in the above 45 cities total 22,076 or 85 per cent of the total reported, 25,837, for the two year period.

EXHIBIT 1

BUREAU OF NARCOTICS
TREASURY DEPARTMENT
WASHINGTON 25, D.C.

INTERIM REPORT ON NARCOTIC ADDICTION SURVEY

January 1, 1953—April 30, 1955

Total Reported Shown By State

Alabama	111	Nebraska	60
Arizona	128	Nevada	68
Arkansas	72	New Hampshire	15
California	2,350	New Jersey	443
Colorado	116	New Mexico	38
Connecticut	110	New York	9,458
Delaware	3	North Carolina	128
District of Columbia	887	North Dakota	14
Florida	249	Ohio	785
Georgia	197	Oklahoma	108
Idaho	4	Oregon	86
Illinois	7,172	Pennsylvania	323
Indiana	176	Rhode Island	16
Iowa	30	South Carolina	107
Kansas	50	South Dakota	5
Kentucky	871	Tennessee	136
(USPHSH 796)		Texas	771
Louisiana	106	Utah	4
Maine	47	Vermont	3
Maryland	247	Virginia	112
Massachusetts	186	Washington	200
Michigan	1,229	West Virginia	41
Minnesota	123	Wisconsin	165
Mississippi	134	Wyoming	4
Missouri	535		
Montana	1	<i>Total</i>	28,224
		Territory of Alaska	22
		Territory of Hawaii	268
		<i>Grand Total</i>	28,514

EXHIBIT 2

BUREAU OF NARCOTICS TREASURY DEPARTMENT
WASHINGTON 25, D.C.INTERIM REPORT ON NARCOTIC ADDICTION SURVEY
January 1, 1955—April 30, 1955

State and City

Alabama	10	Indiana	13
Birmingham	3	Gary	9
Montgomery	1	Other	4
Other	6		
Arizona	26	Iowa	6
Phoenix	23	Des Moines	4
Tucson	2	Other	2
Other	1	Kansas	11
Arkansas	15	Topeka	0
Little Rock	8	Other	11
Other	7	Kentucky	33
California	624	(USPHSH 29)	
Los Angeles	462	Louisiana	11
San Francisco	115	New Orleans	7
Oakland	12	Other	4
Other	35	Maine	14
Colorado	10	Bangor	2
Denver	8	Other	12
Other	2	Maryland	28
Connecticut	11	Baltimore	28
Bridgeport	2	Other	0
Waterbury	2	Massachusetts	32
Other	7	Boston	18
Delaware	0	Lynn	2
District of Columbia	168	Other	12
Florida	56	Michigan	275
Miami	45	Detroit	275
Alford	3	Other	0
Other	8	Minnesota	26
Georgia	47	Minneapolis	19
Atlanta	22	St. Paul	4
Augusta	3	Other	3
Savannah	4	Mississippi	16
Other	18	Jackson	3
Idaho	2	Other	13
Grangeville	2	Missouri	103
Illinois	488	Kansas City	25
Chicago	485	St. Louis	74
Other	3	Other	4

SPECIAL COMMITTEE

INTERIM REPORT ON NARCOTIC ADDICTION SURVEY (Con'd)

January 1, 1955-April 30, 1955

State and City

Montana	0	South Carolina	28
Nebraska	14	Greenville	8
Omaha	11	Spartanburg	3
Other	3	Other	17
Nevada	0	South Dakota	1
New Hampshire	1	Tennessee	4
New Jersey	60	Jackson	1
Newark	38	Knoxville	1
Jersey City	3	Other	2
Other	19	Texas	94
New Mexico	8	San Antonio	53
Albuquerque	5	El Paso	13
Other	3	Houston	8
New York	1,771	Dallas	4
New York City ..	1696	Fort Worth	3
Buffalo	14	Other	13
Other	61	Utah	0
North Carolina	2	Vermont	1
Snow Hill	1	Virginia	2
Other	1	Norfolk	1
North Dakota	2	Other	1
Flora	2	Washington	33
Other	0	Seattle	19
Ohio	298	Tacoma	10
Cleveland	200	Other	4
Cincinnati	89	West Virginia	7
Toledo	7	Wisconsin	37
Other	2	Milwaukee	30
Oklahoma	17	Madison	5
Tulsa	11	Other	2
Oklahoma City ..	2	Wyoming	0
Other	4		
Oregon	14	Total	4,448
Portland	12	Territory of Alaska	0
Other	2	Territory of Hawaii	23
Pennsylvania	35	Honolulu	15
Pittsburgh	13	Other	8
Philadelphia	5		
Other	17	Grand Total	4,471
Rhode Island	0		

EXHIBIT 3

BUREAU OF NARCOTICS—TREASURY DEPARTMENT WASHINGTON 25, D.C.

INTERIM REPORT ON THE SURVEY OF ADDICTION IN THE UNITED STATES (1953-54)

TABLE B

TOTALS REPORTED BY AREAS AND AGE GROUPS

Area	Age Group				Sex		Total
	Under 21	21-30	31-40	Over 40	Male	Female	
New England States.....	16	114	57	131	216	102	318
New York and Northern New Jersey...	1,355	4,179	1,518	885	5,846	2,091	7,937
Pennsylvania, Delaware and Southern New Jersey.....	21	171	85	147	306	118	424
Maryland, District of Columbia, N. Carolina, Virginia and West Virginia.	89	528	266	331	923	291	1,214
Georgia, Florida, Alabama and South Carolina.....	7	82	93	341	356	167	523
Kentucky and Tennessee (USPHSH-767)	33	368	226	343	728	242	970
Michigan and Ohio.....	113	858	331	139	1,196	245	1,441
Illinois, Indiana and Wisconsin.....	1,102	3,874	1,266	733	6,199	776	6,975
Texas, Louisiana and Mississippi.....	91	298	167	334	663	227	890
Missouri, Kansas, Arkansas and Oklahoma	68	307	99	145	495	124	619
Minnesota, Iowa, Nebraska, North Dakota, South Dakota.....	2	44	42	95	104	79	183
Colorado, Utah, Wyoming, and New Mexico.....	4	23	16	101	94	50	144
California, Nevada and Arizona.....	219	1,043	357	277	1,488	408	1,896
Washington, Oregon, Idaho, Montana, Territory of Alaska.....	13	85	95	71	195	69	264
Territory of Hawaii.....	12	122	57	54	188	57	245
Total.....	3,145	12,096	4,675	4,127	18,997	5,046	24,043

NOTE: As of July 1, 1954 the estimated population of the United States was 162,414,000.

Of this total 102,244,000 were 21 years of age and over.

Population age groups are given as follows by the Bureau of the Census:

15-19 years	11,055,000
20-24 years	10,899,000
25-29 years	11,900,000
30-34 years	12,343,000
35-39 years	11,495,000
40-44 years	11,091,000
45-49 years	9,884,000
50-54 years	8,674,000
55-59 years	7,746,000
60-64 years	6,575,000
65-69 years	5,259,000
69-74 years	3,973,000

EXHIBIT 4

BUREAU OF NARCOTICS
TREASURY DEPARTMENT
WASHINGTON 25, D.C.

INTERIM REPORT ON THE SURVEY OF ADDICTION IN THE UNITED STATES (1953-54)

TABLE C

TOTAL REPORTED SHOWN BY STATE

Alabama	101	Nebraska	46
Arizona	102	Nevada	68
Arkansas	57	New Hampshire	14
California	1,726	New Jersey	383
Colorado	106	New Mexico	30
Connecticut	99	New York	7,687
Delaware	3	North Carolina	126
Dist. of Columbia	719	North Dakota	12
Florida	193	Ohio	487
Georgia	150	Oklahoma	91
Idaho	2	Oregon	72
Illinois	6,684	Pennsylvania	288
Indiana	163	Rhode Island	16
Iowa	24	South Carolina	79
Kansas	39	South Dakota	4
Kentucky	838	Tennessee	132
(USPHSH 767)		Texas	677
Louisiana	95	Utah	4
Maine	33	Vermont	2
Maryland	219	Virginia	110
Massachusetts	154	Washington	167
Michigan	954	West Virginia	40
Minnesota	97	Wisconsin	128
Mississippi	118	Wyoming	4
Missouri	432		
Montana	1	<i>Total</i>	23,776
		Territory of Alaska	22
		Territory of Hawaii	245
		<i>Grand Total</i>	24,043

EXHIBIT 5 (Amended)

BUREAU OF NARCOTICS—TREASURY DEPARTMENT—WASHINGTON 25, D.C.

INTERIM REPORT ON THE SURVEY OF ADDICTION IN THE UNITED STATES (1953-54)

TABLE D

TOTAL REPORTED BY AREA SHOWING DRUG USED

Area	Drug Used						Total
	Heroin	Mor- phine	Opium	Synthe- tics	Co- caine*	Mari- huana	
New England States.....	133	99	13	64	.....	9	318
New York and Northern New Jersey.....	7,343	300	25	180	16	73	7,937
Pennsylvania, Delaware and Southern New Jersey.....	182	108	6	87	.....	41	424
Maryland, District of Columbia, N. Carolina, Virginia and West Virginia.....	785	183	47	111	.....	88	1,214
Georgia, Florida, Alabama and South Carolina.....	52	223	6	234	.....	8	523
Kentucky and Tennessee (USPHSH-767).....	547	262	9	152	.....	.....	970
Michigan and Ohio.....	1,066	149	7	80	.....	139	1,441
Illinois, Indiana and Wisconsin.	5,933	301	17	285	.....	439	6,975
Texas, Louisiana and Mississippi	414	310	32	80	.....	54	890
Missouri, Kansas, Arkansas and Oklahoma.....	361	163	15	36	.....	44	619
Minnesota, Iowa, Nebraska, North Dakota, South Dakota	40	91	13	32	.....	7	183
Colorado, Utah, Wyoming.....	8	37	51	47	.....	1	144
California, Nevada and Arizona	1,506	84	77	88	.....	141	1,896
Washington, Oregon, Idaho, Montana, Territory of Alaska	165	42	19	26	.....	12	264
Territory of Hawaii.....	178	7	16	14	.....	30	245
Total.....	18,713	2,359	353	1,516	16	1,086	24,043
Percentages.....	77.83	9.81	1.47	6.30	.07	4.52	

* Included in totals reported as addicts.

EXHIBIT 6

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Alabama—										
Birmingham.....	3	4	2	0	0	1	2	2	0	0
Montgomery.....	6	6	2	4	0	0	2	4	0	0
Mobile.....	21	16	2	0	0	19	1	0	0	15
Other.....	4	4	2	2	0	0	2	2	0	0
Totals.....	34	30	8	6	0	20	7	8	0	15
Arizona—										
Phoenix.....	48	32	29	0	19	0	15	0	17	0
Tucson.....	38	37	1	26	0	11	1	25	0	11
Other.....	9	8	2	2	1	4	2	1	1	4
Totals.....	95	77	32	28	20	15	18	26	18	15
Arkansas—										
Little Rock.....	2	2	2	0	0	0	2	0	0	0
Hot Springs.....	1	1	1	0	0	0	1	0	0	0
Other.....	4	1	0	2	0	2	0	1	0	0
Totals.....	7	4	3	2	0	2	3	1	0	0
California—										
San Francisco.....	488	237	72	319	21	76	72	112	18	35
Los Angeles.....	7,146	2,878	74	7,042*	30	.....	54	2,802*	22	.....
San Diego.....	300	136	1	153	8	138	1	62	0	73
Oakland.....	125	48	15	61	0	49	12	11	1	24
Sacramento.....	233	119	17	140	8	68	14	76	6	23
Fresno.....	76	42	17	34	0	25	13	18	0	11
Other.....	757	313	17	300	4	436	14	125	7	167
Totals.....	9,125	3,773	213	8,049	71	792	180	3,206	54	333
Colorado—										
Denver.....	76	51	6	0	58	12	5	1	38	7
Other.....	10	2	0	1	7	2	0	0	0	2
Totals.....	86	53	6	1	65	14	5	1	38	9
Connecticut—										
Hartford.....	24	10	16	6	0	2	1	6	1	2
Bridgeport.....	0	3	0	0	0	0	3	0	0	0
New Haven.....	11	2	1	9	0	1	2	0	0	0
Other.....	54	50	4	43	3	4	4	39	3	4
Totals.....	89	65	21	58	3	7	10	45	4	6
Delaware—										
Wilmington.....	12	12	0	9	1	2	0	9	1	2
Other.....	1	1	1	0	0	0	1	0	0	0
Totals.....	13	13	1	9	1	2	1	9	1	2
District of Columbia.....	309	163	61	230	11	7	42	112	7	2
Florida—										
Miami.....	42	34	18	10	5	9	10	8	9	7
Jacksonville.....	32	23	2	21	6	3	1	15	6	1
Tampa.....	17	13	1	14	0	2	1	11	0	1
Other.....	21	21	3	13	5	0	3	13	5	0
Totals.....	112	91	24	58	16	14	15	47	20	9

*Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Georgia—										
Atlanta.....	34	22	0	28	4	2	1	15	4	2
Augusta.....	2	0	2	0	0	0	0	0	0	0
Columbus.....	3	3	0	3	0	0	0	3	0	0
Other.....	18	17	11	7	0	0	14	3	0	0
Totals.....	57	42	13	38	4	2	15	21	4	2
Idaho—										
Boise.....	4	3	0	1	0	3	2	1	0	0
Other.....	5	0	0	4	0	1	0	0	0	0
Totals.....	9	3	0	5	0	4	2	1	0	0
Illinois—										
Chicago.....	4,608	1,885	234	4,100	20	254	117	1,654	26	88
Other.....	13	17	5	5	3	0	8	7	2	0
Totals.....	4,621	1,902	239	4,105	23	254	125	1,661	28	88
Indiana—										
Indianapolis.....	99	13	0	83	0	16	0	10	0	3
Evansville.....	25	12	0	25	0	0	0	12	0	0
Fort Wayne.....	3	3	0	0	0	3	0	0	0	3
Gary.....	108	35	21	72	5	10	10	17	3	5
South Bend.....	50	13	0	31	0	19	0	9	0	4
Totals.....	285	76	21	211	5	48	10	48	3	15
Iowa—										
Des Moines.....	18	13	0	17	0	1	0	12	0	1
Council Bluffs.....	4	1	0	4	0	0	0	1	0	0
Other.....	3	0	0	3	0	0	0	0	0	0
Totals.....	25	14	0	24	0	1	0	13	0	1
Kansas—										
Kansas City.....	2	1	0	0	0	2	0	0	0	1
Wichita.....	9	3	0	4	0	5	0	2	0	1
Other.....	12	9	1	8	2	1	1	5	2	1
Totals.....	23	13	1	12	2	8	1	7	2	3
Kentucky—										
Louisville.....	12	20	2	6	0	4	5	5	6	4
Lexington.....	16	15	7	0	9	0	2	0	13	0
Other.....	33	8	7	6	20	0	0	2	6	0
Totals.....	61	43	16	12	29	4	7	7	25	4
Louisiana—										
New Orleans.....	501	85	41	305	46	109	28	15	25	17
Other.....	28	15	2	4	12	10	1	1	8	5
Totals.....	529	100	43	309	58	119	29	16	33	22
Maine—										
Augusta.....	1	1	1	0	0	0	1	0	0	0
Auburn.....	2	2	1	1	0	0	1	1	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	3	3	2	1	0	0	2	1	0	0
Maryland—										
Baltimore.....	135	92	0	83	0	52	0	58	0	34
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	135	92	0	83	0	52	0	58	0	34

* Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953 (Cont.)

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Massachusetts—										
Boston.....	331	282	32	296*	3	.....	34	248*	0	.....
Springfield.....	4	6	0	4	0	0	1	4	1	0
Other.....	42	40	0	42*	0	.....	0	39*	1	.....
Totals.....	377	328	32	342*	3	0	35	291*	2	0
Michigan—										
Detroit.....	1,681	75	67	1,591	23	0	33	34	8	0
Kalamazoo.....	5	1	0	5	0	0	0	1	0	0
Grand Rapids.....	8	3	0	3	0	5	1	2	0	0
Totals.....	1,694	79	67	1,599	23	5	34	37	8	0
Minnesota—										
Minneapolis.....	44	21	9	26	2	7	3	10	1	7
St. Paul.....	22	3	3	9	4	6	1	2	0	0
Other.....	5	1	0	0	3	2	0	1	1	0
Totals.....	71	25	12	35	9	15	4	12	2	7
Mississippi—										
Jackson.....	5	2	2	2	0	1	2	0	0	0
Other.....	25	15	5	15	0	5	3	9	0	3
Totals.....	30	17	7	17	0	6	5	9	0	3
Missouri—										
Kansas City.....	95	30	21	70*	4	.....	17	10*	3	.....
St. Louis.....	103	28	25	73	4	1	17	8	2	1
Other.....	7	2	0	6	1	0	0	2	0	0
Totals.....	205	60	46	149	9	1	34	20	5	1
Montana—										
Butte.....	2	2	2	0	0	0	2	0	0	0
Miles City.....	3	0	0	3	0	0	0	0	0	0
Billings.....	2	2	0	0	0	2	0	0	0	2
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	7	4	2	3	0	2	2	0	0	2
Nebraska—										
Omaha.....	24	10	3	12	0	9	1	3	0	6
Other.....	3	3	1	2	0	0	1	2	0	0
Totals.....	27	13	4	14	0	9	2	5	0	6
Nevada—										
Las Vegas.....	22	17	0	0	22	0	1	0	16	0
Reno.....	5	1	2	0	3	0	0	0	1	0
Totals.....	27	18	2	0	25	0	1	0	17	0
New Hampshire.....	0	0	0	0	0	0	0	0	0	0
New Jersey—										
Newark.....	463	301	18	399	1	45	11	270	0	20
Atlantic City.....	74	67	17	40	4	13	17	34	4	12
Camden.....	22	21	9	8	1	4	9	8	0	4
Trenton.....	20	20	3	14	0	3	3	14	0	3
Patterson.....	16	16	1	13	0	2	1	13	0	2
Others.....	86	80	8	50	6	22	6	50	2	22
Totals.....	681	505	56	524	12	89	47	389	6	63
New Mexico—										
Albuquerque.....	61	46	7	2	49	3	0	5	14	27
Gallup.....	6	3	0	0	0	6	0	0	3	0
Las Cruces.....	4	3	0	0	0	4	0	0	3	0
Other.....	4	4	0	0	3	1	0	0	3	1
Totals.....	75	56	7	2	52	14	0	5	23	28

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
New York—										
New York City....	3,919	3,243	249	3,605*	65	.....	224	2,978*	41	.....
Buffalo.....	79	71	16	61	1	1	19	49	2	1
White Plains.....	27	24	0	3	0	24	0	3	0	2
Mineola.....	11	10	0	9	0	2	0	9	0	1
Rochester.....	9	2	0	1	0	8	0	0	0	2
Newburgh.....	5	4	0	5	0	0	0	4	0	0
Syracuse.....	3	1	0	3	0	0	0	1	0	0
Other.....	36	15	0	27	0	9	0	11	0	4
Totals.....	4,089	3,370	265	3,714	66	44	243	3,055	43	29
North Carolina—										
Fayetteville.....	7	7	3	0	4	0	3	0	4	0
Greensboro.....	4	4	3	1	0	0	3	1	0	0
Greenville.....	1	1	1	0	0	0	1	0	0	0
Totals.....	12	12	7	1	4	0	7	1	4	0
North Dakota—										
Bismarck.....	2	0	0	2	0	0	0	0	0	0
Hettinger.....	2	1	1	1	0	0	0	1	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	4	1	1	3	0	0	0	1	0	0
Ohio—										
Cleveland.....	293	231	62	198	2	31	53	152	1	25
Dayton.....	112	75	41	60	1	10	30	40	0	5
Cincinnati.....	97	82	27	59	3	8	21	51	2	8
Toledo.....	29	29	16	4	7	2	16	4	7	2
Youngstown.....	19	17	0	19	0	0	0	17	0	0
Akron.....	9	5	0	8	0	1	0	4	0	1
Springfield.....	8	0	5	0	3	0	0	0	0	0
Other.....	8	5	0	2	3	3	0	2	0	3
Totals.....	575	444	151	350	19	55	120	270	10	44
Oklahoma—										
Oklahoma City....	155	71	5	148*	2	.....	2	68*	1	.....
Tulsa.....	15	11	3	4	8	0	3	0	8	0
Other.....	35	28	3	18	7	7	2	17	2	7
Totals.....	205	110	11	170	17	7	7	85	11	7
Oregon—										
Portland.....	65	38	7	40	6	12	6	16	6	10
Salem.....	2	2	0	0	2	0	0	0	2	0
Eugene.....	1	1	0	0	0	1	0	0	0	1
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	68	41	7	40	8	13	6	16	8	11
Pennsylvania—										
Philadelphia.....	1,048	395	51	960	7	30	40	337	6	12
Pittsburgh.....	310	206	40	261	0	9	35	164	0	7
Harrisburg.....	13	11	0	10	0	3	0	8	0	3
Totals.....	1,371	612	91	1,231	7	42	75	509	6	22
Rhode Island—										
Providence.....	7	7	1	6	0	0	3	2	2	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	7	7	1	6	0	0	3	2	2	0

* Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
South Carolina—										
Columbia.....	7	2	2	5	0	0	2	0	0	0
Greenville.....	2	1	1	1	0	0	1	0	0	0
Other.....	1	3	1	0	0	0	3	0	0	0
Totals.....	10	6	4	6	0	0	6	0	0	0
South Dakota—										
Aberdeen.....	2	0	0	2	0	0	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	2	0	0	2	0	0	0	0	0	0
Tennessee—										
Memphis.....	18	17	5	0	13	0	9	0	8	0
Nashville.....	12	5	4	0	8	0	2	0	3	0
Other.....	9	3	7	0	2	0	1	0	2	0
Totals.....	39	25	16	0	23	0	12	0	13	0
Texas—										
Houston.....	284	146	56	75	56	97	45	12	54	35
Dallas.....	151	42	13	44	44	50	8	1	31	2
San Antonio.....	142	122	64	16	49	13	54	10	49	9
Fort Worth.....	44	33	29	2	12	1	21	2	9	1
Other.....	819	459	68	71	216	464	56	10	204	189
Totals.....	1,440	802	230	208	377	625	184	35	347	236
Utah—										
Salt Lake City....	48	49	0	38	2	8	0	38	4	7
Ogden.....	6	6	0	2	2	2	0	2	0	4
Provo.....	3	3	0	3	0	0	0	3	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	57	58	0	43	4	10	0	43	4	11
Vermont—										
Rutland.....	1	1	1	0	0	0	1	0	0	0
Montpelier.....	1	0	0	1	0	0	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	2	1	1	1	0	0	1	0	0	0
Virginia—										
Richmond.....	4	2	0	1	0	3	0	1	0	1
Norfolk.....	8	6	0	5	0	3	0	4	0	2
Newport News.....	2	2	0	2	0	0	0	2	0	0
Other.....	2	2	0	1	0	1	0	1	0	1
Totals.....	16	12	0	9	0	7	0	8	0	4
Washington—										
Seattle.....	75	57	36	25	13	1	25	20	11	1
Yakima.....	10	10	0	0	10	0	0	0	10	0
Tacoma.....	9	5	0	2	3	4	0	1	2	2
Other.....	9	11	0	4	0	5	3	3	2	3
Totals.....	103	83	36	31	26	10	28	24	25	6
West Virginia—										
Charleston.....	9	4	5	4	0	0	1	3	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	9	4	5	4	0	0	1	3	0	0

*Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1953 (Cont'd)

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Wisconsin—										
Milwaukee.....	157	121	8	107	2	40	2	77	2	40
Kenosha.....	1	1	0	1	0	0	0	1	0	0
Hurley.....	1	1	1	0	0	0	1	0	0	0
Totals.....	159	123	9	108	2	40	3	78	2	40
Wyoming—										
Cheyenne.....	6	6	0	0	5	1	0	0	5	1
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	6	6	0	0	5	1	0	0	5	1
Grand Totals.....	26,986	13,379	1,774	21,853	999	2,360	1,332	10,186	780	1,081
Alaska—										
Anchorage.....	6	13	2	0	4	0	10	0	3	0
Fairbanks.....	2	1	2	0	0	0	1	0	0	0
Kodiak.....	2	2	2	0	0	0	2	0	0	0
Juneau.....	1	1	0	0	0	1	0	0	1	0
Totals.....	11	17	6	0	4	1	13	0	4	0
Hawaii—										
Honolulu.....	101	49	24	60	5	12	21	2	24	2
Hilo.....	2	0	0	0	0	2	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	103	49	24	60	5	14	21	2	24	2

EXHIBIT 7

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Alabama—										
Birmingham.....	16	12	4	10	2	0	4	5	2	1
Montgomery.....	3	3	3	0	0	0	3	0	0	0
Mobile.....	10	8	0	6	0	4	1	3	0	4
Other.....	9	2	3	4	0	2	1	1	0	0
Totals.....	38	25	10	20	2	6	9	9	2	5
Arizona—										
Phoenix.....	38	20	15	1	21	1	4	1	14	1
Florence.....	6	6	0	3	0	3	0	3	0	3
Yuma.....	7	6	3	0	4	0	3	0	3	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	51	32	18	4	25	4	7	4	17	4
Arkansas—										
Little Rock.....	3	2	1	1	1	0	1	0	1	0
Other.....	15	2	2	12	1	0	1	1	0	0
Totals.....	18	4	3	13	2	0	2	1	1	0
California—										
San Francisco.....	413	280	97	229	6	81	83	153	9	35
Los Angeles.....	5,315	1,528	73	5,021*	18	203	84	1,341	14	89
San Diego.....	369	260	4	149	6	210	3	151	13	93
Oakland.....	175	94	43	94	2	36	32	47	0	15
Sacramento—										
Stockton.....	192	139	13	113	16	50	16	79	13	31
Fresno.....	118	89	1	90	1	26	7	60	1	21
Others.....	825	483	8	320	2	495	9	207	1	266
Totals.....	7,407	2,873	239	6,016*	51	1,101	234	2,038	51	550
Colorado—										
Denver.....	33	38	7	4	21	1	7	0	29	2
Other.....	8	2	1	0	7	0	0	1	0	1
Totals.....	41	40	8	4	28	1	7	1	29	3
Connecticut—										
Hartford.....	58	51	11	47	0	0	17	34	0	0
New Haven.....	21	21	1	18	2	0	1	18	2	0
Other.....	14	9	0	8	0	6	0	6	0	3
Totals.....	93	81	12	73	2	6	18	58	2	3
Delaware—										
Wilmington.....	8	8	0	7	0	1	0	7	0	1
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	8	8	0	7	0	1	0	7	0	1
District of Columbia	237	139	53	164	3	17	46	84	5	4
Florida—										
Miami.....	69	47	22	25	4	18	12	22	3	10
Jacksonville.....	13	21	0	13	0	0	0	16	0	5
Tampa.....	7	6	0	3	0	4	0	6	0	0
Other.....	32	12	6	18	0	8	3	7	0	2
Totals.....	121	86	28	59	4	30	15	51	3	17

* Includes narcotic and marihuana arrests in Los Angeles.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Georgia—										
Atlanta.....	27	22	5	19	3	0	5	17	0	0
Savannah.....	6	3	0	5	1	0	1	1	1	0
Columbus.....	0	0	0	0	0	0	0	0	0	0
Other.....	4	4	0	3	0	1	2	2	0	0
Totals.....	37	29	5	27	4	1	8	20	1	0
Idaho—										
Mountain Home...	1	0	1	0	0	0	0	0	0	0
Weiser.....	1	1	0	0	0	1	0	0	0	1
Payette.....	1	0	0	0	0	1	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	3	1	1	0	0	2	0	0	0	1
Illinois—										
Chicago.....	2,035	1,465	82	1,616	11	326	90	1,269	21	85
Other.....	11	6	1	7	2	1	0	1	2	3
Totals.....	2,046	1,471	83	1,623	13	327	90	1,270	23	88
Indiana—										
Indianapolis.....	27	12	19	8	0	0	7	5	0	0
Evansville.....	8	2	0	8	0	0	1	1	0	0
Fort Wayne.....	9	0	0	0	0	9	0	0	0	0
Gary.....	41	14	0	41	0	0	0	14	0	0
South Bend.....	19	6	0	15	0	4	0	5	0	1
Other.....	9	5	0	8	0	1	0	5	0	0
Totals.....	113	39	19	80	0	14	8	30	0	1
Iowa—										
Des Moines.....	15	6	0	11	0	4	0	4	0	3
Other.....	8	3	0	4	0	4	0	0	0	2
Totals.....	23	9	0	15	0	8	0	4	0	5
Kansas—										
Kansas City.....	3	0	0	3	0	0	0	0	0	0
Whichita.....	1	1	0	0	1	0	0	0	1	0
Other.....	6	2	0	5	1	0	0	1	1	0
Totals.....	10	3	0	8	2	0	0	1	2	0
Kentucky—										
Louisville.....	41	35	10	9	14	8	5	9	13	8
Lexington.....	344	356	0	338*	6	0	7	338*	11	0
Other.....	21	12	1	1	19	0	3	3	6	0
Totals.....	406	403	11	348	39	8	15	350	30	8
Louisiana—										
New Orleans.....	212	85	9	101	15	87	9	25	12	39
Other.....	31	19	1	10	2	18	1	5	3	10
Totals.....	243	104	10	111	17	105	10	30	15	49
Maine.....	0	0	0	0	0	0	0	0	0	0

*Kentucky Habitual Addict Law.

* Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Maryland—										
Baltimore.....	117	105	10	77	0	30	10	72	0	23
Other.....	6	4	1	3	2	0	1	3	0	0
Totals.....	123	109	11	80	2	30	11	75	0	23
Massachusetts—										
Boston.....	283	195	20	285*	5	0	9	182*	4	0
Springfield.....	6	5	1	5	0	0	0	5	0	0
Other.....	21	17	2	18	0	1	0	16	0	1
Totals.....	310	217	23	281	5	1	9	203	4	1
Michigan—										
Detroit.....	1,884	355	105	1,485	30	264	17	272	13	53
Flint.....	25	9	0	19	0	6	0	6	0	3
Saginaw.....	13	5	0	13	0	0	0	5	0	0
Other.....	2	0	0	2	0	0	0	0	0	0
Totals.....	1,924	369	105	1,519	30	270	17	283	13	56
Minnesota—										
Minneapolis.....	19	21	2	16	0	1	3	16	1	1
St. Paul.....	4	7	0	0	0	4	3	0	4	0
Other.....	3	2	0	3	0	0	0	2	0	0
Totals.....	26	30	2	19	0	5	6	18	5	1
Mississippi—										
Jackson.....	3	1	2	1	0	0	0	1	0	0
Other.....	4	8	1	2	0	1	4	4	0	0
Totals.....	7	9	3	3	0	1	4	5	0	0
Missouri—										
Kansas City.....	153	50	53	81	9	10	33	10	5	2
St. Louis.....	147	31	28	114	0	5	20	11	0	0
Other.....	5	0	0	5	0	0	0	0	0	0
Totals.....	305	81	81	200	9	15	53	21	5	2
Montana—										
Billings.....	9	3	0	3	0	6	0	0	0	3
Helena.....	3	1	0	3	0	0	0	1	0	0
Totals.....	12	4	0	6	0	6	0	1	0	3
Nebraska—										
Omaha.....	31	14	6	17	1	7	6	7	0	1
Other.....	10	7	0	4	0	6	0	2	0	5
Totals.....	41	21	6	21	1	13	6	9	0	6
Nevada—										
Las Vegas.....	28	16	10	2	16	0	6	0	10	0
Reno.....	2	1	2	0	0	0	1	0	0	0
Other.....	18	1	0	16	0	2	0	0	0	1
Totals.....	48	18	12	18	16	2	7	0	10	1
New Hampshire—										
Concord.....	1	1	0	1	0	0	0	1	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	1	1	0	1	0	0	0	1	0	0

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
New Jersey—										
Newark.....	236	231	1	227	0	8	8	214	1	8
Atlantic City.....	39	39	0	29	0	10	0	29	0	10
Asbury Park.....	13	13	10	1	2	0	10	1	2	0
Camden.....	10	10	0	10	0	0	0	10	0	0
Other.....	98	99	8	79	3	8	8	79	4	8
Totals.....	396	392	19	346	5	26	26	333	7	26
New Mexico—										
Albuquerque.....	36	27	10	2	14	10	7	1	16	3
Roswell.....	9	0	0	0	9	0	0	0	0	0
Other.....	0	2	0	0	0	0	0	0	2	0
Totals.....	45	29	10	2	23	10	7	1	18	3
New York—										
New York City...	4,518	3,322	198	3,937	4	379	237	2,910	28	147
Buffalo.....	84	71	14	60	0	10	18	44	1	8
Syracuse.....	17	14	0	17	0	0	0	14	0	0
Mincola.....	17	16	0	16	0	1	0	15	0	1
White Plains.....	18	15	0	11	0	7	0	9	0	6
Troy.....	9	7	0	9	0	0	0	7	0	0
Rochester.....	7	7	0	5	0	2	0	3	0	4
Other.....	26	16	3	14	1	8	2	8	0	6
Totals.....	4,696	3,468	215	4,069	5	407	257	3,010	29	172
North Carolina—										
Greensboro.....	29	29	27	2	0	0	27	2	0	0
Asheville.....	7	0	7	0	0	0	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	36	29	34	2	0	0	27	2	0	0
North Dakota—										
Fargo.....	1	1	0	1	0	0	0	1	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	1	1	0	1	0	0	0	1	0	0
Ohio—										
Cleveland.....	373	319	67	300*	6	0	45	269*	5	0
Cincinnati.....	80	70	17	46	5	12	14	41	4	11
Dayton.....	60	40	21	33	3	3	11	25	1	3
Columbus.....	40	25	18	15	4	3	9	12	1	3
Toledo.....	13	10	4	0	7	2	4	0	6	0
Youngstown.....	10	9	0	9	0	1	0	8	0	1
Akron.....	12	7	0	11	0	1	0	6	0	1
Other.....	5	5	0	4	0	1	0	4	0	1
Totals.....	593	485	127	418	25	23	83	365	17	20
Oklahoma—										
Oklahoma City...	80	35	4	76*	0	0	1	34*	0	0
Tulsa.....	10	3	0	2	0	8	0	1	0	2
Other.....	14	4	4	3	2	5	2	0	2	0
Totals.....	104	42	8	81	2	13	3	35	2	2
Oregon—										
Portland.....	61	57	10	45	1	5	6	41	5	5
Eugene.....	4	4	0	2	0	2	0	2	0	2
Other.....	5	6	0	4	0	1	0	4	0	2
Totals.....	70	67	10	51	1	8	6	47	5	9

* Includes narcotics and marihuana.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Pennsylvania—										
Philadelphia.....	1,731	568	12	1,675	0	44	1	548	0	19
Pittsburgh.....	214	76	14	193	3	4	13	57	2	4
Harrisburg.....	3	3	0	3	0	0	0	3	0	0
Other.....	16	15	1	13	0	2	0	13	0	2
Totals.....	1,964	662	27	1,884	3	50	14	621	2	25
Rhode Island—										
Providence.....	8	2	1	2	5	0	0	0	2	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	8	2	1	2	5	0	0	0	2	0
South Carolina—										
Columbia.....	4	2	2	2	0	0	2	0	0	0
Greenville.....	2	1	1	1	0	0	1	0	0	0
Other.....	9	9	3	2	4	0	3	2	4	0
Totals.....	15	12	6	5	4	0	6	2	4	0
South Dakota—										
Aberdeen.....	1	0	0	1	0	0	0	0	0	0
Other.....	0	0	0	0	0	0	0	0	0	0
Totals.....	1	0	0	1	0	0	0	0	0	0
Tennessee—										
Memphis.....	16	21	6	2	7	1	10	2	8	1
Nashville.....	12	10	7	3	2	0	4	0	6	0
Knoxville.....	5	4	5	0	0	0	4	0	0	0
Other.....	13	9	10	1	2	0	7	0	2	0
Totals.....	46	44	28	6	11	1	25	2	16	1
Texas—										
Houston.....	363	133	59	130	38	136	44	14	29	46
San Antonio.....	150	104	18	66	17	49	36	30	21	17
Dallas.....	97	43	8	49	6	34	12	2	24	5
Fort Worth.....	25	18	6	8	7	4	11	0	6	1
Other.....	779	365	72	61	257	389	50	20	153	142
Totals.....	1,414	663	163	314	325	612	153	66	233	211
Utah—										
Salt Lake City....	5	2	2	0	3	0	1	0	1	0
Other.....	2	0	1	0	1	0	0	0	0	0
Totals.....	7	2	3	0	4	0	1	0	1	0
Vermont—										
Montpelier.....	0	0	0	0	0	0	0	0	0	0
Other.....	1	1	0	1	0	0	0	1	0	0
Totals.....	1	1	0	1	0	0	0	1	0	0
Virginia—										
Richmond.....	9	6	1	7	0	1	1	4	0	1
Norfolk.....	7	6	5	2	0	0	4	2	0	0
Other.....	3	4	2	1	0	0	3	1	0	0
Totals.....	19	16	8	10	0	1	8	7	0	1

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES DURING 1954

—Continued

State	Totals		Arrests				Convictions			
	Arrests	Con- victions	Narcotics		Marihuana		Narcotics		Marihuana	
			Fed.	Local	Fed.	Local	Fed.	Local	Fed.	Local
Washington—										
Seattle.....	69	82	26	21	19	3	43	19	18	2
Spokane.....	12	12	0	7	0	5	0	7	0	5
Tacoma.....	4	3	0	4	0	0	0	3	0	0
Other.....	9	8	0	4	3	2	0	4	3	1
Totals.....	94	105	26	36	22	10	43	33	21	8
West Virginia—										
Charleston.....	4	1	1	3	0	0	1	0	0	0
Other.....	3	3	0	3	0	0	0	3	0	0
Totals.....	7	4	1	6	0	0	1	3	0	0
Wisconsin—										
Milwaukee.....	149	106	0	104	0	45	0	79	0	27
Other.....	3	3	1	0	0	2	1	0	0	2
Totals.....	152	109	1	104	0	47	1	79	0	29
Wyoming—										
Cheyenne.....	2	7	0	0	2	0	0	0	6	1
Other.....	2	0	0	0	2	0	0	0	0	0
Totals.....	4	7	0	0	4	0	0	0	6	1
Grand Totals.....	23,365	12,346	1,430	18,059	694	3,182	1,243	9,182	581	1,340
Alaska—										
Anchorage.....	14	7	10	0	4	0	2	0	5	0
Fairbanks.....	2	3	1	0	1	0	2	0	1	0
Totals.....	16	10	11	0	5	0	4	0	6	0
Hawaii—										
Honolulu.....	110	34	40	36	13	21	27	0	5	2
Other.....	3	2	0	0	1	2	0	0	0	2
Totals.....	114	36	40	36	14	23	27	0	5	4

EXHIBIT 8

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953-1954

(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			<i>Federal</i>	<i>Local</i>	<i>Federal</i>	<i>Local</i>
Alabama—						
Arrests.....	1953	34	8	6	0	20
	1954	38	10	20	2	6
Convictions.....	1953	30	7	8	0	15
	1954	25	9	9	2	5
Arizona—						
Arrests.....	1953	95	32	28	20	15
	1954	51	18	4	25	4
Convictions.....	1953	77	18	26	18	15
	1954	32	7	4	17	4
Arkansas—						
Arrests.....	1953	7	3	2	0	2
	1954	18	3	13	2	0
Convictions.....	1953	4	3	1	0	0
	1954	4	2	1	1	0
California—						
Arrests.....	1953	9,125	213	8049*	71	792
	1954	7,407	239	6,016*	51	1,101
Convictions.....	1953	3,773	180	3,206*	54	333
	1954	2,873	234	2,038*	51	550
Colorado—						
Arrests.....	1953	86	6	1	65	14
	1954	41	8	4	28	1
Convictions.....	1953	53	4	1	38	9
	1954	40	7	1	29	3
Connecticut—						
Arrests.....	1953	89	21	58	3	7
	1954	93	12	73	2	6
Convictions.....	1953	65	10	45	4	6
	1954	81	18	58	2	3
Delaware—						
Arrests.....	1953	13	1	9	1	2
	1954	8	0	7	0	1
Convictions.....	1953	13	1	9	1	2
	1954	8	0	7	0	1
District of Columbia—						
Arrests.....	1953	309	61	230	11	7
	1954	237	53	164	3	17
Convictions.....	1953	163	42	112	7	2
	1954	139	46	84	5	4
Florida—						
Arrests.....	1953	112	24	58	16	14
	1954	121	28	59	4	30
Convictions.....	1953	91	15	47	20	9
	1954	86	15	51	3	17

*Includes narcotics and marihuana in Los Angeles.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953-1954

(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			<i>Federal</i>	<i>Local</i>	<i>Federal</i>	<i>Local</i>
Georgia—						
Arrests.....	1953	57	13	38	4	2
	1954	37	5	27	4	1
Convictions.....	1953	42	15	21	4	2
	1954	29	8	20	1	0
Idaho—						
Arrests.....	1953	9	0	5	0	4
	1954	3	1	0	0	2
Convictions.....	1953	3	2	1	0	0
	1954	1	0	0	0	1
Illinois—						
Arrests.....	1953	4,621	239	4,105	23	254
	1954	2,046	83	1,623	13	327
Convictions.....	1953	1,902	125	1,661	28	88
	1954	1,471	90	1,270	23	88
Indiana—						
Arrests.....	1953	285	21	211	5	48
	1954	113	19	80	0	14
Convictions.....	1953	76	10	48	3	15
	1954	39	8	30	0	1
Iowa—						
Arrests.....	1953	25	0	24	0	1
	1953	23	0	15	0	1
Convictions.....	1953	14	0	13	0	1
	1954	9	0	4	0	5
Kansas—						
Arrests.....	1953	23	1	12	2	8
	1954	10	0	8	2	0
Convictions.....	1953	13	1	7	2	3
	1954	3	0	1	2	0
Kentucky—						
Arrests.....	1953	61	16	12	29	4
	1954	406*	11	348*	39	8
Convictions.....	1953	43	7	7	25	4
	1954	403*	15	350*	30	8
Louisiana—						
Arrests.....	1953	529	43	309	58	119
	1954	243	10	111	17	105
Convictions.....	1953	100	29	16	33	22
	1954	104	10	30	15	4
Maine—						
Arrests.....	1953	3	2	1	0	0
	1954	0	0	0	0	0
Convictions.....	1953	3	2	1	0	0
	1954	0	0	0	0	0
Maryland—						
Arrests.....	1953	135	0	83	0	52
	1954	123	11	80	2	30
Convictions.....	1953	92	0	58	0	34
	1954	109	11	75	0	23

*338 under Kentucky Habitual Addict Law

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953-1954

(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			Federal	Local	Federal	Local
Massachusetts—						
Arrests.....	1953	377	32	342*	3	0
	1954	310	23	281*	5	1
Convictions.....	1953	328	35	291*	2	0
	1954	217	9	203*	4	1
Michigan—						
Arrests.....	1953	1,694	67	1,599	23	5
	1954	1,924	105	1,519	30	270
Convictions.....	1953	79	34	37	8	0
	1954	369	17	283	13	56
Minnesota—						
Arrests.....	1953	71	12	35	9	15
	1954	26	2	19	0	5
Convictions.....	1953	25	4	12	2	7
	1954	30	6	18	5	1
Mississippi—						
Arrests.....	1953	30	7	17	0	6
	1954	7	3	3	0	1
Convictions.....	1953	17	5	9	0	3
	1954	9	4	5	0	0
Missouri—						
Arrests.....	1953	205	46	149	9	1
	1954	305	81	200	9	15
Convictions.....	1953	60	34	20	5	1
	1954	81	53	21	5	2
Montana—						
Arrests.....	1953	7	2	3	0	2
	1954	12	0	6	0	6
Convictions.....	1953	4	2	0	0	2
	1954	4	0	1	0	3
Nebraska—						
Arrests.....	1953	27	4	14	0	9
	1954	41	6	21	1	13
Convictions.....	1953	13	2	5	0	6
	1954	21	6	9	0	6
Nevada—						
Arrests.....	1953	27	2	0	25	0
	1954	48	12	18	16	2
Convictions.....	1953	18	1	0	17	0
	1954	18	7	0	10	1
New Hampshire—						
Arrests.....	1953	0	0	0	0	0
	1954	1	0	1	0	0
Convictions.....	1953	0	0	0	0	0
	1954	1	0	1	0	0
New Jersey—						
Arrests.....	1953	681	56	524	12	89
	1954	396	19	346	5	26
Convictions.....	1953	505	47	389	6	63
	1954	392	26	333	7	26

*Includes narcotics and marihuana in Boston.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953-1954

(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			Federal	Local	Federal	Local
New Mexico—						
Arrests.....	1953	75	7	2	52	14
	1954	45	10	2	23	10
Convictions.....	1953	56	0	5	23	28
	1954	29	7	1	18	3
New York—						
Arrests.....	1953	4,089	265	3,714*	66	44
	1954	4,696	215	4,069	5	407
Convictions.....	1953	3,370	243	3,055*	43	29
	1954	3,468	257	3,010	29	172
North Carolina—						
Arrests.....	1953	12	7	1	4	0
	1954	36	34	2	0	0
Convictions.....	1953	12	7	1	4	0
	1954	29	27	2	0	0
North Dakota—						
Arrests.....	1953	4	1	3	0	0
	1954	1	0	1	0	0
Convictions.....	1953	1	0	1	0	0
	1954	1	0	1	0	0
Ohio—						
Arrests.....	1953	575	151	350	19	55
	1954	593	127	418	25	23
Convictions.....	1953	444	120	270	10	44
	1954	485	83	365	17	20
Oklahoma—						
Arrests.....	1953	205	11	170	17	7
	1954	104	8	81	2	13
Convictions.....	1953	110	7	85	11	7
	1954	42	3	35	2	2
Oregon—						
Arrests.....	1953	68	7	40	8	13
	1954	70	10	51	1	8
Convictions.....	1953	41	6	16	8	11
	1954	67	6	47	5	9
Pennsylvania—						
Arrests.....	1953	1,371	91	1,231	7	42
	1954	1,964	27	1,884	3	50
Convictions.....	1953	612	75	509	6	22
	1954	662	14	621	2	25
Rhode Island—						
Arrests.....	1953	7	1	6	0	0
	1954	8	1	2	5	0
Convictions.....	1953	7	3	2	2	0
	1954	2	0	0	2	0
South Carolina—						
Arrests.....	1953	10	4	6	0	0
	1954	15	6	5	4	0
Convictions.....	1953	6	6	0	0	0
	1954	12	6	2	4	0

*Includes marihuana in New York City.

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953-1954
(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			<i>Federal</i>	<i>Local</i>	<i>Federal</i>	<i>Local</i>
South Dakota—						
Arrests.....	1953	2	0	2	0	0
	1954	1	0	1	0	0
Convictions.....	1953	0	0	0	0	0
	1954	0	0	0	0	0
Tennessee—						
Arrests.....	1953	39	16	0	23	0
	1954	46	28	6	11	1
Convictions.....	1953	25	12	0	13	0
	1954	44	25	2	16	1
Texas—						
Arrests.....	1953	1,440	230	208	377	625
	1954	1,414	163	314	325	612
Convictions.....	1953	802	184	35	347	236
	1954	663	153	66	233	211
Utah—						
Arrests.....	1953	57	0	43	4	10
	1954	7	3	0	4	0
Convictions.....	1953	58	0	43	4	11
	1954	2	1	0	1	0
Vermont—						
Arrests.....	1953	2	1	1	0	0
	1954	1	0	1	0	0
Convictions.....	1953	1	1	0	0	0
	1954	1	0	1	0	0
Virginia—						
Arrests.....	1953	16	0	9	0	7
	1954	19	8	10	0	1
Convictions.....	1953	12	0	8	0	4
	1954	16	8	7	0	1
Washington—						
Arrests.....	1953	103	36	31	26	10
	1954	94	26	36	22	10
Convictions.....	1953	83	28	24	25	6
	1954	105	43	33	21	8
West Virginia—						
Arrests.....	1953	9	5	4	0	0
	1954	7	1	6	0	0
Convictions.....	1953	4	1	3	0	0
	1954	4	1	3	0	0
Wisconsin—						
Arrests.....	1953	159	9	108	2	40
	1954	152	1	104	0	47
Convictions.....	1953	123	3	78	2	40
	1954	109	1	79	0	29
Wyoming—						
Arrests.....	1953	6	0	0	5	1
	1954	4	0	0	4	0
Convictions.....	1953	6	0	0	5	1
	1954	7	0	0	6	1

NARCOTIC ARRESTS AND CONVICTIONS IN THE UNITED STATES 1953—1954

(Comparative by States)

State	Year	Total	Narcotics		Marihuana	
			Federal	Local	Federal	Local
Grand Totals—						
Arrests.....	{ 1953	26,986	1,774	21,853	999	2,360
	{ 1954	23,365	1,430	18,059	694	3,182
Convictions.....	{ 1953	13,379	1,332	10,186	780	1,081
	{ 1954	12,346	1,243	9,182	581	1,340
Alaska—						
Arrests.....	{ 1953	11	6	0	4	1
	{ 1954	16	11	0	5	0
Convictions.....	{ 1953	17	13	0	4	0
	{ 1954	10	4	0	6	0
Hawaii—						
Arrests.....	{ 1953	103	24	60	5	14
	{ 1954	114	40	36	14	23
Convictions.....	{ 1953	49	21	2	24	2
	{ 1954	36	27	0	5	4

APPENDIX W

AUTOMOTIVE TRAFFIC INTO CANADA

Province	Customs Ports	July—1954		March—1955	
		Month	Daily	Month	Daily
British Columbia.....	Pacific Highway.....	67,460	2,176	28,389	915
Alberta.....	Coutts.....	12,463	402	5,286	170
Saskatchewan.....	North Patrol.....	8,176	264	3,516	113
Manitoba.....	Emerson.....	20,355	657	5,838	186
Ontario.....	Fort Erie.....	394,636	12,730	78,361	2,528
	Niagara Falls.....	272,505	8,790	100,318	3,236
	Windsor.....	345,189	11,135	170,004	5,488
Quebec.....	Blackpool.....	68,820	2,220	13,488	435
	Rock Island.....	41,630	1,343	15,924	514
Maritimes.....	St. Stephen.....	92,226	2,975	55,382	1,786

APPENDIX X

DEEPSEA OR OCEAN-GOING COMMERCIAL VESSELS ENTERING FOUR CANADIAN PORTS DURING 1952 AND 1953

(Taken from the Annual Report of the National Harbours Board for the year 1953)

Port	1952	1953
Halifax.....	1,614	1,531
Quebec.....	737	753
Montreal.....	1,476	1,736
Vancouver.....	1,361	1,533

APPENDIX Y

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APPENDIX Z

DRUG ADDICTION

By George E. Trasov, B.A., M.S.W., Social Worker, Drug Addiction Research, University of British Columbia, Vancouver, B.C.

Honourable members of the Senate, may I be privileged to present my evidence regarding the problems of Drug Addiction. I do so with reluctance and timidity purely on the basis that there is a tendency to classify individuals presenting my point of view as visionaries and theorists. I am neither. My evidence is based on training, experience, and insight. I represent my point of view at this time as a citizen of Vancouver and a father of a family. By the same token I am expressing the view of many parents in this city. My professional point of view in the field of research on the problems of drug addiction was presented by my Director and Colleague, Dr. G. H. Stevenson.

The evidence submitted by various individuals on the problems of drug addiction and your presence here represents great progress in society's attitude toward drug addiction, yet from the point of view of "prevention" not only of drug addiction but juvenile delinquency and maladaptation generally little was said. Without sound approach to the problems of juvenile delinquency of which drug addiction is only one facet the elaborate apparatus set up in the Opium and Narcotic Drug Statutes—highly desirable as it is from a humanitarian standpoint, cannot be too successful in curing or even curbing drug addiction.

Many members giving evidence to the Honourable members of the Senate referred frequently to four groups of addicts, namely, (1) members of the medical, dental, nursing and veterinary professions, (2) persons who are receiving medical treatment for relief of physiological illness, (3) criminal addicts and (4) non-criminal addicts, that is, persons who are using drugs but who have not been brought to the attention of the police. From my own point of view there are only two groups: (1) persons who are receiving medical treatment for relief of physiological illness, and (2) addicts. Addicts in the latter classification are delinquents by definition. That is they are violators of statutes relating to illegal use of narcotics. This conclusion is a personal one and depends largely upon my definition of delinquency. I like to use the etymological definition of delinquency meaning, "to fall away". A delinquent is a person, who in his behaviour falls away from the customs and mores of the social organization. Such a broad definition would include any narcotic drug user in the category of a delinquent. This definition would support authorities on delinquency, such as Bronner, Heally, Burt and Gluecks.

Detailed comparisons were made by the above named authorities, between delinquents and non-delinquents. They concluded that the commonest and the most disastrous conditions leading to delinquency are those centered about the family life. The question of the effects of family relationship upon the sum total of home influence affecting one child in the family in one way and another child in the same family in a very different way has also been answered by these authorities. Briefly, a delinquent sibling is described as the one who at some stage of his development has been blocked in his needs for a satisfying relationship in the family.

All delinquents fall into a general pattern. They are emotionally disturbed people afraid to face life, unless it be a life of delinquency, and unable to make the adjustments necessary to normal living. They are all seeking to avoid the decisions and responsibilities of daily life. Some find in narcotics, the escape

they desire. At the present time we place delinquents in custody to prevent further delinquency and to protect society from their criminal activities. At the expiration of their sentences we return these unfortunates to society, the same emotionally disturbed individuals they were before incarceration. In a short time most of them revert to the old pattern of life—crime or addiction and crime, and soon come again before the court for sentence. This process repeats itself time and time again. *Emphasis is still laid on protecting society not in understanding the individual.*

Those who are more sophisticated in understanding personality recognize that there are many factors contributing to delinquency and its various manifestations, including drug addiction, some of which are generally cultural—over-crowding, poor economic status, influence of the gang and exploitation by underworld barons who deliberately trap the weak. Some of these factors are very important, even though many of us were susceptible to the same factors, but the most *significant ones are those which center around relationships.*

Relationships originate in the home—with the mother, father and siblings. In this setting we usually find the clue to the delinquents and delinquent addict's underdeveloped social personality. The child who is unable to identify with his parents and siblings can hardly be expected to identify with the individuals in the society, to adjust to the society and the social customs of which their parents are a part. Children can only see the world through the eyes of their parents. Conflict with the parents subsequently brings about conflict with the society at large.

Among the forces that count most in determining whether or not a boy will be conditioned to antisocial behaviour is therefore the home atmosphere and especially the intimate emotional relationships of the parent and child and their psychological deposits in the personality and character of the boy. Whether we accept the point of view of common sense psychology, or the more penetrating psychoanalytic explanation in terms of unsatisfactory growth and relationships of id, ego and superego during the first few years of life, it is clear that in the home and in the parent-child relations are to be found the crucial roots of character which make for acceptable or unacceptable adjustment to the realities of life in society. *Little progress can be expected in the prevention of delinquency or drug addiction until family life is strengthened by a large-scale, continuous pervasive program designed to bring to bear all the resources of mental hygiene, social work, education, and religious and ethical instruction upon the central issue. We must break the vicious circle of character-damaging influence on children exerted by parents, who are themselves the distorted personality products of adverse parental influences, (victims of circumstances beyond their control) through intensive instruction of each generation of prospective parents in the elements of mental hygiene and the requisites of happy and healthy family life. A tremendous multiplication of psychiatric, social, and other resources for improving the basic equipment of present and prospective parents for a wholesome parental role has become indispensable. Without this, we shall continue the attempt to sweep back the mounting tides of delinquency and eventual manifestation of delinquency through addiction with an outworn broom.*

There are many difficulties associated with treatment and prevention of juvenile delinquency. Nevertheless, social action should be concentrated in the areas in which specific attack on the problem of childhood maladjustment is possible and promising. To this end, society must do its most intensive work farther upstream in the life-span. At present, the greatest amount of time, thought, energy, and money is devoted to dealing with the finished product of long-operative antisocial processes. The professional and financial resources devoted to the early stages of childhood, to the education of youngsters in

healthy and law-abiding self-management, and to the instruction of young parents in the mental hygiene of family life are petty compared with those poured into the social stream for the maintenance of criminal courts, prisons, and parole boards, when it is often too late for effective results. Society will continue to suffer from excessive delinquency and crime until it focuses much greater attention on childhood and family life.

I should like to express my strong belief that narcotic drug addiction is a symptom. It is a symptom of not one but of a variety of social maladies that appear in the various levels of our social structure—from the local peddler or the family which does not provide the right environment up to the international trade seeking illicit gain.

One may view drug addiction as one symptom of a deep seated social problem of larger cities—a problem which may manifest itself through other symptoms also, such as truancy, gang warfare and delinquency generally.

The basic problem for which there is no single term is the result of various deprivations suffered by children and their families in crowded, impoverished slum areas, in areas of racial conflict but basically in areas where the family and the community fail to provide the basic physical, emotional and educational needs of children. A major difficulty is that we are *inclined to take this basic social illness for granted as inevitable* but when one of its symptoms comes to our notice, such as an outbreak of gang warfare or drug addiction, there is a somewhat frenzied effort to deal with the presenting symptoms while continuing to ignore the basic problem.

Basic problems cannot be successfully attacked piecemeal. It requires combined operations by all—and a genuine co-operative and sustained effort based upon the best strategic planning available.

The whole political and social structure of the city is involved in this basic problem to some degree as is also that of the nation. If we are really talking about the roots of drug addiction we are talking about basic maladjustment in our social structure, especially in larger urban centres. We are attacking one of the most difficult problems that this society faces, and I believe the problem is going to be with us for many years if we direct our energies to the symptoms without touching upon the basic problem. There is no doubt that new synthetics will replace opium. The opium supply of the world will be left to Mr. Luciano, so we shall have more problems.

I fully realize, Honourable Members of the Senate, that your term of reference is narcotic addiction. You may need to discount my presentation. But you have been referred to as a history making body. Though I do not wish to minimize your importance, I do feel that the significance of such history may be minimized considerably unless you consider the basic problems underlying delinquency generally. *The focus must be on the home and community.*

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